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HIV HEALTH SERVICES PLANNING COUNCIL

January 6, 1992

The Agenda of this meeting is missing.

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SF MINUTES

SF
H22
#2
1/6/92

HIV HEALTH SERVICES PLANNING COUNCIL
January 6, 1992
4:30 - 7:00 p.m.

Members Present: Sandra Hernandez, Pierre Ludington, Michael Baxter, Pat Christen, Moher Downing, Yvonne Frazier, Estela Garcia, Jaime Geaga, Anne Guillory-Thom, Steve Lew, J.B. Molaghan, Darol Nance, Bob Nelson, Veneita Porter, Eric Rofes, Laura Thomas, Mary Jane Wood

Members Absent: Marcy Fraser (U), Gerald Lenoir (E), Gifford Leoung (U), Mike Shriver (E), Reggie Williams (E), Sylvia Villareal (E)

Staff Present: Bill Haskell, Valerie Dorr, Jon Dean Green

Interpreters: Carol Sue Richardson Perez, Phil La Barbera

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I. Roll Call

Roll Call was taken as above.

II. Review of Minutes

The minutes of December 16, 1991, were approved.

III. Council Composition Overview

Dr. Hernandez spoke on the composition of the Planning Council. David French has resigned from the Planning Council for personal reasons, effective immediately. Anne Guillory-Thom will be resigning from the Planning Council effective February 15, 1992. Currently, responses have not yet been received from persons representing hemophiliacs, gay Latinos, the incarcerated, and the union. There has been an acceptance from a person representing women with HIV. The AIDS Office is currently preparing a report for Mayor Jordan on the Planning Council and its activities. There will be up to five seats on the Planning Council for the new Mayor to fill.

IV. Review of CARE Application Awards

Judith Weld, Operations Branch, AIDS Office (AO), spoke on the CARE application awards. Ms. Weld reviewed the various types of services offered under each service category.

Dr. Hernandez then discussed the amount recommended for funding to People of Color (POC) agencies. The amount recommended under this round of CARE monies was 6%. Dr. Hernandez reminded the Planning Council of its October 14, 1991 target percentage of

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CARE monies to be funded to POC agencies in 92-93 (18-24%). The Planning Council was under their target percentage by 12%. Dr. Hernandez spoke on several options available to the Planning Council to reach its level of recommended funding for POC agencies. The Planning Council could reprioritize services called for and relook at services. The Planning Council could relook at proposals not funded or disqualified. Lastly, the Planning Council could do a set aside of funds specifically for POC agencies and do another Request for Proposals (RFP).

A question was raised concerning RFP review teams and how strictly the teams adhered to priority services. Jon Dean Green pointed out that the Planning Council had decided to fund only the areas called for in the RFP application and no others.

A question was raised concerning the number of proposals that were disqualified for not responding to a priority service. Should the Planning Council look again at its service priorities to reassess them for responsiveness to the needs of the community?

A motion was made to review proposals disqualified for non-responsiveness to priority areas. After discusion, it was decided that this would not be a fair process in that it would exclude agencies that did not respond in the first place because the agency wanted to provide services in service areas not called for. The motion was withdrawn.

A question was next raised on the amount of monies being sought by the City overall in CARE funds. Dr. Hernandez stated that with the $4.7 million in new Supplemental funds being sought in conjunction with the funds from Year 01, approximatly $18 million was being requested. The next question was whether San Francisco was not applying deep enough. A concern was raised on whether the review teams for this round had made their decisions thinking there were funding limits and subsequently made recommendations with a economic scarcity in mind. The next question was how were amounts decided? Dr. Hernandez stated that review teams were told to review proposals and evaluate on the basis of deliverables only. The only caps were the maximum dollar amounts in each category. Dr. Hernandez said she felt it inappropriate to try and second guess the review teams. Ms. Weld stated that all review teams were reminded that there was no limit on the number of agencies or amount of money to individual agencies that the review teams could recommend.

Several Planning Council members at this point stated that in response to the discussion of the percentage of funds to be targeted to POC agencies, they felt the Planning Council must stand by its earlier committment to target between 18 & 24% of new monies. They felt that POC agencies know their communities and are the most appropriate providers to deliver services to those communities.

The point was made that the one application per agency per service area rule should be reexamined, particularly with reference to large agencies with multiple HIV programs. The AIDS

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Office staff were also commended for the technical assistance provided during the RFP and for the clarity of the RFP application.

A) The following motion was passed by the Planning Council:

> The AO should prepare a summary of proposals submitted and disqualified by POC agencies. The AO should solicit input from the CDBG work group and POC advisory group. Services should be prioritized, a dollar amount assigned and set aside and an RFP performed.

VI. Renegotiation of Next Year's Contracts

Postponed till next meeting

VII. Integration of New CARE Priorities Into Existing Priorities

Dr. Hernandez asked the Planning Council to consider the following for the next meeting:

a) Where to put new contracts in previous priorities?

b) Where to place EMA augmentation?

c) Where (if any) to put new DPH requests?

CARE Formula Budget Summary
February 1, 1992 – January 31, 1993

ervice	Type of Service	Provider	Amount	Subtotal	%
dministration			$415,498	$415,498	5.0%
lanning Council Support		SFDPH – AO	$255,687	$255,687	3.1%
ontinuation of San Francisco Service Demonstration Project				$1,081,127	13.0%
SDP Consortia Support		SFDPH – AO	$320,027		
SDP Programs			$761,100		
Minority Outpatient Care		SFDPH – SFGH	$104,279		
Mental Health Services		UCSF – AHP	$109,608		
Home Health & Hospice		VNH	$185,916		
Adult Day Health Care		Continuum	$160,930		
Consolidated Food Services		Project Open Hand	$52,114		
Minority Attendant Care		Westside	$96,140		
Money Management		Coming Home Support	$52,113		
ase Management				$743,915	9.0%
Special Programs for Youth		SFDPH – CPHS	$192,308		
Case Management for Women & Children		SFDPH – CPHS	$55,712		
Eligibility Counseling & Advocacy		A.B.C.	$231,415		
Legal Serv. for Eligibility Hearings		AIDS L.R.P.	$78,375		
Case Management		Health Outreach Team	$122,579		
Case Management & Advocacy Training		UCSF – AHP	$63,526		
ousing				$926,236	11.1%
Long–Term Residen. Drug & Alcohol Rx		Walden House	$209,000		
Emergency Housing Payments		AIDS Emergency Fund	$196,460		
Emergency Housing Vouchers		SF AIDS Foundation	$100,686		
Housing Case Management		A.I.D.S.	$261,250		
Residential Counselor & Child Care		Catholic Charities	$54,340		
Congregate Care Housing		Shanti Project	$104,500		
rimary Medical Care				$2,017,211	24.3%
Primary Care Services		SFDPH – CPHS	$895,421		
Early Intervention Clinic		SFDPH – SFGH	$70,551		
Ward 86, AIDS Medical Clinic		SFDPH – SFGH	$174,877		
Psychiatric Consultation/Liaison		SFDPH – SFGH	$106,878		
Early Diag. & Treatment Intervention		SFDPH – Forensics	$116,349		
Early Intervention Medical Services		SFCCC	$209,000		
HIV Drug Program		SFGH	$444,135		
ubstance Abuse Treatment				$618,603	7.4%
Ward 92, HIV–IDU Medical Clinic		SFDPH – SFGH	$212,980		
Substance Abuse Treatment		SFDPH – CSAS	$76,249		
Outpat. Substance Abuse Counseling		18th St. Services	$151,724		
Outpat.M.H. & Subst. Abuse Services		Operation Concern	$58,285		
Outpat. M.H. & Subst. Abuse Services		A.I.D.S.	$119,365		
ther Primary Health Care				$947,792	11.4%
Mental Health Case Management		SFDPH – CMHS	$97,088		
Outreach & Mental Health Services		UCSF Ctr on Deafness	$27,275		
Residential Attendant Care Services		Catholic Charities	$99,850		
Outpat. Psych Consult. & Counseling		UCSF – AHP	$119,862		
Home/Hospice Care		PPMC – VNH	$282,150		
Case Management & Practical Support		AIAI	$73,150		
Bulk Purchases & Home–Delivered Food		Project Open Hand	$130,625		
Bulk Purchases & Home–Delivered Food		SF Food Bank	$117,792		

Psychosocial Support			$757,929	9.1%
Peer Counseling & Practical Support	Shanti Project	$209,000		
Emotional Support Services	TARC	$57,078		
Vol. Recruitment, Child Care Serv.	The Bridge for Kids	$46,158		
Volunteer Training, Home Care	Home Care Companions	$43,368		
Emotional Group Peer Support	BAHSES-BWMT/MACT	$78,375		
Phone Crisis Intervention/Hotline	SF Suicide Preven.	$62,700		
Outreach & Early Intervention	GMC/EACH	$120,629		
Outreach & Early Intervention	Project Inform	$36,121		
Psychosocial Support	IFR	$104,500		
San Mateo and Marin Counties			$545,965	6.6%
Early Intervention & Case Management	San Mateo County	$306,223		
Primary Medical Care Services	Marin County	$239,742		
GRAND TOTAL, FORMULA BUDGET:			$8,309,963	100.0%

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

January 9, 1992

YEAR 02 WORKING GROUP MEETINGS,
PUBLIC COMMENT AND HEARING

JAN 10 '92

Ryan White CARE Act of 1990, Title II

Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990. The Act authorized federal funds for health care and support services for persons with HIV infection and AIDS. In response, the California Department of Health Services, Office of AIDS, organized the HIV Comprehensive Care Working Group, representing a broad diversity of perspectives, to begin the community planning process. The resulting plan was embodied in the State's application to the Health Resources and Services Administration.

The Working Group reconvened in Sacramento December 4, 1991 to begin planning for Year 02. Subsequent meetings will begin at 9:30 a.m. January 16 and at 8:30 a.m. January 17 in San Diego. The final meeting is scheduled for February 5 in San Jose (see the enclosed announcement for locations). Among the issues to be addressed are:

- *statewide funding allocation methodology*
- *consortia membership requirements*
- *funding of drug therapies*
- *home and community-based care issues*
- *continuation of health insurance premium payments*
- *special health and support services to women, infants, children, and families*
- *federal, state, and local roles and responsibilities.*

All interested persons, including representatives of county and city governments, health officials, and community organizations representing diverse population groups within the State are encouraged to attend these meetings. ***Public comment will be solicited on January 16 prior to the Working Group's deliberations. Persons who plan to comment should bring a written copy of their remarks.***

The Working Group will complete a draft application for funding January 17. A copy of the draft will be available from the Office of AIDS January 29, 1992. ***Copies may be obtained by completing the enclosed form.*** *A* ***public hearing*** *on the draft plan will be held* ***February 4 in San Jose.*** *This hearing will begin with a review of the proposed use and distribution of Title II funds, followed immediately by public comment. The Working Group will make final decisions on the Year 02 plan at the February 5 meeting. Written comments will also be accepted and must be received in the Office of AIDS by 5:00 p.m. February 10, 1992.*

For further information contact Lura Franzella, Office of AIDS, (916) 323-3740.

Enclosure

Ryan White Care Act, Title II
Year 02

PUBLIC COMMENT/PUBLIC HEARING LOCATION

PUBLIC COMMENT	PUBLIC HEARING
January 16, 1992*	February 4, 1992
10:00 - 10:40 a.m.	1:30 - 3:30 p.m.
Holiday Inn On The Bay 1355 North Harbor Drive San Diego, CA 92101 (619) 232-3861	Le Baron Hotel 1350 North 1st Street San Jose, CA 95112 (408) 453-6200

*Bring a written copy of your comments to this meeting.

Public comment will be limited to three minutes per person at each location.

If you want to receive a copy of the Draft Application for Title II funds, please detach and return the bottom half of this form with a self-addressed mailing label no later than January 22, 1992.

(Staple mailing label here.)

RETURN TO: Department of Health Services
Office of AIDS
Attn: CARE Act Unit
P.O. Box 942732
Sacramento, CA 94234-7320

HIV HEALTH SERVICES PLANNING COUNCIL

January 13, 1992

The Agenda of this meeting is missing.

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1/13/92

HIV HEALTH SERVICES PLANNING COUNCIL
January 13, 1992
4:30 - 8:15 p.m.

Members Present: Sandra Hernandez, Reggie Williams, Michael Baxter, Moher Downing, Marcy Fraser, Yvonne Frazier, Jaime Geaga, Ann Guillory-Thom, Steve Lew, Pierre Ludington, J.B. Molaghan, Darol Nance, Bob Nelson, Eric Rofes, Mike Shriver, Laura Thomas, Mary Jane Wood, Antonio Sanchez

Members Absent: Pat Christen, Estela Garcia, Gerald Lenoir, Gifford Leoung, Veneita Porter, Sylvia Villareal

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Jon Dean Green

Interpreters: Jadine Murello, Carol Sue Richardson-Perez

Introductions were made. Antonio Sanchez was welcomed as a new Planning Council member.

I. Roll Call

Roll Call was taken as above.

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II. Review of Minutes

The minutes of January 13, 1992, were approved.

III. Renegotiation of Year 02 Contracts

Jon Dean Green presented a draft policy to the Planning Council on allowing AIDS Office (AO) program managers to be given the discretion to negotiate changes in units of service (UOS) and unduplicated clients (UDC) with CARE contracting agencies.

A) The following motion was passed by the Planning Council:

> The official policy of the Planning Council will be the maintenance of current unduplicated clients (UDC) and units of service (UOS) for CARE contractors being refunded for Year 02. However, in cases of individual programs, changes will be at the discretion of the AIDS Office program manager. In the case of significant programmatic change (more than 25% change in UDC or UOS, or substantive change in delivery of service) Planning Council approval will be required.

IV. Presentation of Monitorings

Jon Dean Green passed out a Monitoring Summary sheet. Mr. Green explained that the Monitoring Summary was a preliminary report

in that not all monitorings had been completed or had not been turned in. He pointed out that there were three programs that had been recommended for continued funding contingent upon recommendations for change by the review teams.

Questions were raised concerning the monitorings for respite care and 24 hour care. Monitoring teams had recommended: a) respite care being defunded if it did not dramatically increase its UOS by December 31, 1991; and b) reduction of funding from two 24 hour care residences to one 24 hour care residence if a need for both was not demonstrated by 1/31/92.

There were concerns expressed regarding respite care being 93% under its projected UOS. The Planning Council had thought that respite care would be one of the most utilized programs funded in the first cycle of CARE programs. Several Planning Council members questioned whether "respite care" is understood by the community. Respite care by definition is to be used by PWAs with a caregiver, though it is sometimes looked at as being a means of helping a PWA with no caregiver at all. The lack of use of respite care might also be attributed to the time lag between implementation of a program and its full usage by the community.

In regards to the lack of utilization of the 24 hour care residences, Sandra Hernandez pointed out to the Planning Council that many people who are ill do not want to live in group housing situations. Most people want independent living. Questions concerning 24 hour care should not necessarily be viewed as a failure of the organization. The lack of utilization may be that the program design is not attractive to the community. Housing is a very complicated issue and a highly personal choice.

Questions were raised by Planning Council members on when notification of deficiencies were sent to agencies. The suggestion was made that monitoring recommendations should be delayed to give agencies time to respond to deficiencies. Sandra Hernandez reminded the Planning Council that agencies themselves reported the under utilization of programs and therefore should be aware of problems with UOS. She also reminded the Planning Council that deliverables such as UDC and UOS were part of a legal contract that agencies sign with the AIDS Office.

Discussion also took place on the different tacks different teams took in regards to deficiencies in deliverables by contracting agencies. Sandra Hernandez stated that the Monitoring Summary was just that, a summary or abbreviated tool. The Planning Council was reminded that the reason Planning Council members led the monitoring teams was to assure that the overall mission of the Planning Council to fill gaps in service for persons with HIV, was met.

V. Integration of Year 01 and Year 02 Priorities

Sophia Chang detailed changes from Year 01 and Year 02 Formula and Supplemental budgets. Dr. Chang stated that the only item

that had moved from the Year 01 Supplemental budget to the Year 02 Formula budget was the HIV Drug Program. The remainder of the increase in Formula funds from Year 01 to Year 02 was taken up with full funding for the HRSA Service Demonstration Project (SDP) and the 4.5% cost of living allowance (COLA) the Planning Council was allowing. (The HRSA SDP had been funded for a four month period with Year 01 Formula monies to bring it into line with the CARE funding cycle.)

Dr. Chang next spoke on continuation of the Pilot Care home and community based care programs. The current programs are at Westside and the AIDS Office and are supported through State CARE Title II funds. There is, though, question as to whether the State will have adequate Federal funds to continue to fund the Pilot Care programs. These programs have been included in the Supplemental application at their current level of Federal funding, being as they would be gaps in service if they were to no longer be funded. It is expected that State support of the programs will continue at a "level" amount. The Pilot Care program at the AIDS Office is the primary source of care for undocumented persons with HIV in the City.

Dr. Chang then discussed the dollar amount preliminarily set aside in the budget to meet the Planning Council's minimum target percentage for funding to People of Color (POC) agencies. Dr. Chang stated that the AIDS Office Chateau Agape proposal had been awarded to Westside. This causes the amount of "new" funds given to POC agencies to go from 6% to 11.7%. If the AIDS Office decentralizes the AIDS Drug Program, it will go to a minority owned CBO. This combined with the set aside will cause the amount of new monies going to POC agencies to overshoot the minimum 18% mark and come closer to the 24% high end of the range designated by the Planning Council.

A concern was raised by several Planning Council members that the designated service area for the minority set aside was Psychosocial Support.

Michael Shriver next raised the point that the only youth specific service in the approximately $20 million the Planning Council would be requesting was for $123,000. He stated this to be an unacceptably small amount in light of the recent AIDS Office Young Men's Study which demonstrated a high incidence and seroprevalence rate in youth. The point was made by several Planning Council members that youth services need to be specific to youth. If services aren't specific to youth, youth may not be a priority within an agency or youth may feel disenfranchised from the service and not access it.

B) The following motion was passed by the Planning Council:

> That $400,000 be set aside for youth specific services, $200,000 for housing and $200,000 for substance abuse.

The set aside for POC agencies was revisited. Discussion continued on the service area the set aside should be placed under.

C) The following motion was passed by the Planning Council:

> Bring to the People of Color Advisory Committee the six major service area categories and ask the POC Advisory Committee to prioritize the top two. $260,000 each would then be set aside in the two categories designated.

D) The following motion was passed by the Planning Council:

> That the two priority areas identified by the People of Color Advisory Committee be placed at the top of their respective service area categories in the New Services portion of the budget.

Discussion then returned to the Pilot Care home and community based care programs. The consensus of the Planning Council was that these would be a continuation of existing programs similar to the HRSA SDP and should therefore be placed high on the list of new services in the Supplemental Application.

E) The following motion was passed by the Planning Council:

> That the Home and Community Based Care Programs be placed at the top of the list for New Services under the CARE Supplemental Budget.

VII. One Time Savings

Sophia Chang presented the AIDS Office Proposal for the use of one time savings. The AIDS Drug Program set aside of $500,000 was discussed first. The State has expanded the formulary for its AIDS Drug Program and will be able to meet its obligations. The first proposal is for decentralization of the City AIDS Drug Program. This would be done as a pilot, interim program while awaiting decentralization of all Department of Public Health (DPH) services ($200,000). The second proposal would use $184,000 to purchase hospital pharmacy equipment and subsidize unreimbursed AIDS drugs. This would allow for the purchase of infusion pumps, disposable toxic waste containers and non-ADP covered drugs (e.g. acyclovir). The third proposed use of funds would be for Home Infusion Therapy ($116,000). This would allow administration of ganciclovir to persons without access to home infusion services.

There is approximately $500,000 in unexpended DPH program funds. Dr. Chang recommended allowing 20% of funds for one-time operating expenses to individual programs ($100,000). Dr. Chang explained that for the DPH, CARE funds covered only personnel costs. This one time operating expenses would allow for

beepers, xeroxing etc. The next part of this would be for implementation of infection control procedures/equipment in district health centers ($225,000). This would cover the cost of gloves, needle disposal, autoclaves etc. The last recommendation would be to hire an outside consultant to work through the AIDS Office in conjunction with CBOs to develop a system of copayment as mandated under CARE and a strategic implementation plan ($175,000). It would include training of CBOs.

Sandra Hernandez stated that implementation of the copayment plan was a critical investment in the future. As more cities qualify for Title I status, competition for CARE funds will increase. San Francisco will need to generate funds to make up for the any loss of CARE monies.

Eric Rofes questioned the assumption on which the proposal for one-time usage of monies was based. He stated that rather than ADP or DPH savings going back to serve those same areas, that the monies should be used to look at global gaps in service. An example would be for monies to be used around the CDC change in AIDS definition coming on line April 1, 1992. He worries that no one is responding to the upcoming CDC change. Sophia Chang pointed out that she had brought the matter before the AIDS Services Advisory Committee and set up meetings to which only two people came. Sandra Hernandez stated that CBOs must work collaboratively with the AIDS Office on this matter. CBOs did not seem to be stepping forward to address the CDC change. She stated she did not feel it was the AIDS Office place to tell the CBOs what they needed to do around the change, but rather CBOs must take the leadership and inform the AIDS Office what the AIDS Office can do to help the CBOs. Dr. Hernandez further went on to point out that the AIDS Office has already looked at the ramifications of CD4 counts, quality assurance for those tests etc. CBOs must collaborate with each other and the AIDS Office to come to some kind of policy decision and implementation plan. Eric Rofes said he felt that the upcoming change in definition would be an appropriate topic for the Planning Council to take up, especially how to meet the challenge and where the funds should come from.

HIV HEALTH SERVICES PLANNING COUNCIL

January 27, 1992

The Agenda of this meeting is missing.

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HIV HEALTH SERVICES PLANNING COUNCIL
January 27, 1992
4:30 - 8:00 p.m.

Members Present: Sandra Hernandez, Reggie Williams, Michael Baxter, Pat Christen, Moher Downing, Marcy Fraser, Yvonne Frazier, Estela Garcia, Jaime Geaga, Ann Guillory-Thom, Gerald Lenoir, Gifford Leoung, Steve Lew, J.B. Molaghan, Darol Nance, Bob Nelson, Eric Rofes, Mike Shriver, Laura Thomas, Patricia Underwood, Sylvia Villareal, Mary Jane Wood

Members Absent: Pierre Ludington, Veneita Porter, Antonio Sanchez

Staff Present: Sophia Chang, Bill Haskell, Galen Leung, Valerie Dorr, Herman Levias, Jon Dean Green

Interpreters: Philip LaBarbera, Terry Tibble

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes

Minutes of January 13, 1992 were approved with the following change: Page 3, paragraph 5, line 1 "Michael Shriver next raised the point that the only new youth specific..."

III. Approval of Agenda

The agenda was approved as it stood.

IV. Review of Supplemental Contigency Plan

a) Marin County

Mary Jo Buerger, Marin County, spoke on Marin's request for additional funds beyond the monies Marin would be allocated for their percentage of living PWAs within the EMA. Marin was proposing to provide substance abuse counseling, food and nutrition services, and housing assistance to persons with HIV disease in Marin.

A) The following motion was passed by the Planning Council:

> That Marin's request for additional funds to support substance abuse, food/nutrition and housing assistance be approved and placed at the bottom of the Supplemental priority list.

b) Contingency Plan

Sophia Chang next spoke on the contingency plan required as part of the Supplemental grant application. As called for in Table "F" of the application, the Planning Council must designate what it would do if it were to receive only 25%, 50% and 75%

respectively of the Supplemental funds requested.

If the City were to receive only 25% of the funds requested, that would approximately place the cut off point after #19 on the Supplemental Budget. Under this scenario, case management, housing and primary care services funded last year would be covered and all else cut. If the City were to receive only 50% of the funds requested, that would approximately place the cut off point after #44 on the Supplemental budget. Under this scenario, all Supplemental services funded under FY91 would continue to be funded, and pilot care, housing and Communities of Color substance abuse treatment would receive funding. If the City were to receive only 75% of the funds requested, that would approximately place the cut off point after #59 on the Supplemental budget. Under this scenario, new services would be funded to one-half of the way through primary care.

Dr. Chang pointed out that there was another take that could be done on the question of the 25% scenario, in which rather than cutting off funds after #19, all of FY91 services would be continued at 66% funding. The consensus of the Planning Council was that it would do neither an agency nor the client the agency was serving any good to dramatically cut the services offered. Many programs could not take a 33% cut and continue to operate. The opinion was voiced that the Planning Council's role was to encourage robust programs that are able to fully meet a client's needs.

Several Planning Council members then pointed out that even though this discussion was only for the sake of Table F in the Supplemental application, the import of it was vital. Estela Garcia proposed the Planning Council establish a subcommittee to examine long range planning especially in light of shrinking funds and additional Title I cities.

B) The following motion was passed by the Planning Council:

> That for the purposes of Table F, programs be funded in full as far as 25%, 50% or 75% of requested funds would go.

V. AIDS and City Cuts

Sandra Hernandez, Director of the AIDS Office, spoke on how budget cuts would effect the AIDS Office. Dr. Hernandez explained that this discussion comes in three parts. 1) The Mayor's Office gave instructions to all departments to cut 10% of general funds monies accross the board. For the Department of Public Health (DPH) this would be $16 million to $26 million, depending on if one counts revenues or not. The instructions from the Mayor's Office said that the the $16 million cut for the DPH (out of the $160 million budget) should be taken in administration and should not affect service. 2) The DPH needs another $26 million next year to meet its obligations. This is above the $160 million for this year, so next year's budget would be $186 million. 3) The City is receiving approximately $26-$27 million in SB855 funds. The SB855 funds would be coming

to San Francisco General to offset uncompensated MediCal costs. The question is, will the SB855 funds be seen as an offset of the DPH's 10% cut, or just be used to offset the budget deficit?

There are three scenarios with the SB855 monies. i) Some of the monies would go to critically needed programs especially at SFGH. ii) Some of the monies would go to critically needed programs and some to offset the DPH's portion of the deficit. iii) All of the monies will go to offset the deficit. Several Planning Council members asked what the Board of Supervisors wanted to do with the SB855 monies? The Board has a laundry list of things they would like to see the funds spent on. The DPH is currently trying to find ways for the Board's ideas and the DPH's needs to mesh.

Of the $16 million budget deficit for DPH, $700,000 is the AIDS Office portion. $500,000 of the $700,000 is the 4.5% Cost of Living Allowance (COLA) budgeted for this year. The AO doesn't want to cut COLAs. Dr. Hernandez then went on to point out that only 13 of the 90 AO positions are general fund supported. Of these, most are operations staff members who can not be cut without severe problems for contracts or fiscal units. Eric Rofes pointed out the artificiality of the concept that cuts in administration does not effect direct service delivery.

Dr. Hernandez also stated that the DPH did not yet know the effects of Proposition A - Early Retirement. Many nurses and pharmacists are looking to retire, not top hospital administrators. How this will play out is still in question.

The discussion turned again to SB855 funds and how the monies should be spent. Several Planning Council members stated that the Board and new Mayor should be reminded of the expertise of the Planning Council and that the Board and Mayor should call upon the Planning Council to help them in the allocation of AIDS direct service dollars. It was requested that the Mayor, Board of Supervisors and Nancy Pelosi be invited to the Planning Council to begin a dialogue on Citywide AIDS funding.

VI. CPHS Proposal for Funds

Dr. Hernandez spoke on the CPHS proposal for new funds. She began the discussion by saying that since the plan would be placed at the bottom of the list of requested monies from Supplemental, she put the requests into a coherent whole, but did not make cuts or changes in the proposals given to her by the different divisions. Dr. Hernandez stated that this is the first time that the tuberculosis (t.b.) division has requested funds. The t.b. proposal is included because of concerns about drug resistant t.b. and its effect on persons with HIV. Dr. Hernandez pointed out that there are the same number of cases of persons with t.b. this year and last year, the primary difference is that the percentage with HIV has increased. There has not been any reported cases of drug resistant t.b. in San Francisco. Hopefully the t.b. request will help continue that.

Concerns were raised on the request for Ward 86. There is currently no Spanish speaking capacity. Dr. Hernandez pointed

out that staff on Ward 86 are actually UCSF persons, so we can say Spanish speaking preferred and indicate to the team that this is a necessity.

C) The following motion was passed by the Planning Council:

That the CPHS package be accepted as a whole and added to the request for Supplemental funds.

D) The following motion was passed by the Planning Council:

In accepting the funding proposal for Ward 86, the Planning Council strongly encourages the new hires to the proposal have Spanish language capabilities and that in review and evaluation of this program by the Planning Council in the coming year, continued funding will be contingent on Spanish language capabilities.

E) The following motion was passed by the Planning Council:

That the priority for the CPHS proposal be the Health Centers (including SPY and Tom Waddell), SFGH Ward 86, T.B. Control, Emergency Room, DMSF, and Neurology/Neuropsychology.

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AGENDA

HIV HEALTH SERVICES PLANNING COUNCIL
February 10, 1992
3rd Floor Conference Room
25 Van Ness
4:30 - 8:00 p.m.

I.	Roll Call	4:30 - 4:35
II.	Review of Minutes	4:35 - 4:45
III.	Approval of Agenda	4:45
IV.	Update of General Fund Budget Issues for FY 92-93	4:45 - 5:15
V.	One Time Funds Usage	5:15 - 5:45
VI.	Chateau Agape Update	5:45 - 6:00
VII.	Break	6:00 - 6:15
VIII.	Review of Call for Proposals	6:15 - 6:35
IX.	Review/Approve Units of Service Change	6:35 - 6:50
X.	Approval of Indirect Rates	6:50 - 7:05
XI.	Title II Update a) CAEAR Meeting Representative	7:05 - 7:20
XII.	Assessment of Review Process	7:20 - 7:35
XIII.	Public Comment	7:35 - 7:50
XIV.	Development of Next Meeting's Agenda	7:50 - 8:00

HIV HEALTH SERVICES PLANNING COUNCIL

February 10, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL

February 24, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL

March 9, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL
March 9, 1992
4:30 - 7:00 p.m.

Members Present: Reggie Williams, Michael Baxter, Pat Christen, Marcy Fraser, Yvonne Frazier, Estela Garcia, Gerald Lenoir, Steve Lew, Pierre Ludington, Eric Rofes, Mike Shriver, Laura Thomas, Patricia Underwood, Sylvia Villareal, Mary Jane Wood

Members Absent: Sandra Hernandez, Moher Downing, Jaime Geaga, Gifford Leoung, J.B. Molaghan, Darol Nance, Bob Nelson, Antonio Sanchez

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes and Agenda

The minutes of February 24, 1992 and the March 9, 1992 agenda were approved.

III. Role of the Planning Council

Discussion was tabled to a later date.

IV. CAEAR Washington D.C. Update

Discussion was tabled to a later date.

V. Department of Public Health (DPH) Monitorings

Valerie Dorr spoke on the DPH monitorings (see attached summary).

Department of Mental Health, Substance Abuse and Forensics (DMSF)

The Case Management and Acute Psychiatric Care program has experienced problems in hiring. For the case manager, DMSF had originally proposed using a Health Program Coordinator II position to enable DMSF to hire an MFCC. Decentralized personnel unit denied the classification, the decision was appealed and overruled. The position is now classified. The position must pass through DPH accounting, Personnel, the Mayor's Office and the Controller's Office. The R.N. requisition for acute psychiatric care was submitted six months ago. It was lost by DPH personnel. Personnel was unable to find the lost requisition and has requested a new requisition from DMSF. DMSF has identified an individual to fill this position once the requisition has been processed.

Ms. Dorr spoke on the frustration that DMSF and Rinna Flohr are experiencing with Civil Service in the hiring process. Concerns were raised by Planning Council members on the delays in hiring staff and the lack of statistics for persons currently being served under this program.

San Francisco General Hospital (SFGH), Psychiatric Consult/Liason

This is a service provided through an agreement with UCSF AIDS Health Project. All services were up and running in July.

SFGH General Medical Early Intervention Clinic

This is a relatively new program, it is one nurse practitioner with Spanish speaking capabilities.

SFGH Ward 86 Early Intervention Clinic and Acute Drop-In

Problems were identified with low units of service, problems recruiting a minority service provider, and the physical area is cramped and congested.

Concerns raised by the Planning Council members centered around what types of efforts SFGH was putting forward to recruit a minority provider. Several Planning Council members pointed out that it is difficult to recruit minority providers to San Francisco. There is a limited pool of people of color physicians. Many providers do not want to work in a city with a high cost of living, unaffordable housing, for the relatively low pay scale offered at UCSF. The point was made by Pat Christen that if compensation was the critical factor, the Planning Council should examine this area for creative solutions to the problem.

SFGH Ward 92, HIV Substance Abuse

Problems identified with this program are the lack of staff for weekends and evenings and referral problems due to outside agencies lack of capacity. The way persons are selected for case management in this program is by lottery. An innovative feature of the program is its holding groups in city neighborhoods.

Community Public Health Service

A major problem within this program is the delay in hiring of staff. Currently, two R.N. positions are still vacant. The Health Centers have expressed concern on the effect on care of the recently passed Early Retirement Ordinance.

Discussion of the Planning Council turned to the issue of Civil Service delays in overall hiring within the DPH. The consensus of the Planning Council was that lost requisitions (by Civil Service and the Mayor's Office) was completely unacceptable. It was acknowledged that the even though it might be seen to be punitive to the Divisions within DPH, the only way to force

Civil Service and the Department to address the issue of timeliness of hiring would be to defund the unfilled positions. A frustration expressed by the majority of the Planning Council was the lack of concern on Civil Service's part for the emergency nature of the CARE monies. The delays and ineptness of Civil Service were delaying medically necessary services for persons with HIV.

A) The following motion was passed by the Planning Council:

> If the unfilled CARE funded positions described in the DPH program monitorings are not filled within 12 months of the start date of the contracts, the Planning Council should reallocate the funding for those positions elsewhere.

B) The following motion was passed by the Planning Council:

> The above motion shall apply to all CARE funded DPH programs with unfilled positions, including those not yet monitored or with incomplete monitorings.

The Planning Council then discussed means of addressing the problem with Civil Service recalcitrance. Ideas put forward were to hold conversations with the Mayor's Office and Ray Baxter's Office and bring the situation to the media's attention. Estela Garcia pointed out that it should be clearly delineated that front line service personnel within DPH were not to blame for the delays in hiring. The problem clearly lies at a much higher level within DPH and especially with the Civil Service. The bureaucracy is holding back services to be paid for with emergency funds.

The Planning Council called for the AIDS Office to invite the Director of Health for the City to the March 23, 1992, meeting of the Planning Council.

VI. Review of Call for Proposals Process

Discussion was tabled to a later date.

VII. Public Comment

Joe Gonzalez, DMSF, spoke to the Planning Council on DMSF and its frustration with the Civil Service in hiring personnel. Currently, his office is looking to hire an African American to fill their vacant position. If DMSF is unable to fill that position due to Civil Service delays, that will be a blow to the office's plans to develop a multi-racial and culturally competent staff. Mr. Gonzalez reminded the Planning Council that if funds are reallocated to outside of the DPH, hiring might go more quickly, but access to services within the DPH may be slowed as CBO's might not necessarily have the contacts to make quick referrals or to access immediate services.

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Agenda.

HIV HEALTH SERVICES PLANNING COUNCIL

March 23, 1992
25 Van Ness
3rd Floor Conference Room
4:30 - 6:30 p.m.

I. Roll Call

II. Review and Approve Minutes and Agenda

III. DPH Personnel Hiring Update

IV. Approval of CARE Title II Letter of Intent
a)Decision making process

V. Role of the Planning Council

VI. CAEAR Update

VII. Use of One Time Funds

VIII. Review of Care Application Process

IX. Public Comment

X. Agenda Development

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HIV HEALTH SERVICES PLANNING COUNCIL
March 23, 1992
4:30 - 7:00 p.m.

Members Present: Sandra Hernandez, Reggie Williams, Marcy Fraser, Yvonne Frazier, Estela Garcia, Gifford Leoung, Steve Lew, Pierre Ludington, J.B. Molaghan, Darol Nance, Bob Nelson, Mike Shriver, Laura Thomas, Patricia Underwood, Sylvia Villareal, Mary Jane Wood

Members Absent: Michael Baxter, Pat Christen, Moher Downing, Jaime Geaga, Gerald Lenoir, Eric Rofes, Antonio Sanchez

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Jon Dean Green

Interpreters: John McBride, Catherine Anderson

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes and Agenda

The minutes of March 9, 1992 and the March 23, 1992 agenda were approved.

III. Process for Review of One Time Fund Requests

Sandra Hernandez stated that 15 requests had been received by the AIDS Office in response to the letter asking for information on what CARE contractors would do with $50,000 in one time funds. Dr. Hernandez went on to request parameters from which to analyze the requests.

Dr. Hernandez was asked how much money was available for one time expenditures. She stated she expected at least $500,000 in one time savings. Q - Could the Planning Council cover cuts in existing programs with this money? A - Yes, but the Planning Council had gone on record stating it would not automatically assume cuts in programs. This did not preclude the Planning Council from making the decision to make good mayoral cuts in programs.

Two programs that had not yet begun a) 24 hour dementia care and b) probate conservatorship were not being implemented with general fund monies. It would appear that if the Planning Council wanted, there were enough funds to cover both services for one year only (one-time) and some of the one time requests.

Review guidelines for the proposals were discussed. The consensus of the Planning Council was that the proposals should be considered if they were from a well-utilized program that

could effectively expand its services and that had received a favorable monitoring.

A) The following motion was passed by the Planning Council:

> That one time funds requests be considered only from agencies whose current programs are well utilized, who could effectively expand services and had received a favorable monitoring.

The point was made by several Planning Council members and most clearly put forward by Pat Underwood that it must be made clear to any agency receiving one time funds that these were one time funds and would not be annualized into the next contract. The consensus of the Planning Council was that a review team with no conflict of interest should be assembled to review the requests.

IV. Approval of CARE Title II Letter of Intent

Jon Dean Green stated that in order to apply for CARE Title II funds for Year 02, a letter of intent must be sent to the State. The formula for Title II gives San Francisco level funding ($682,909). The process for applying for Title II monies is that a letter of intent is due in March with the final application due in May.

B) The following motion was passed by the Planning Council:

> To approve the CARE Title II Letter of Intent.

V. Role of the Planning Council
a) Overview of legislated activity

Jean Harris, Special Assistant to the Mayor, was introduced to the Planning Council. Ms. Harris stated that she is the liaison with the Mayor for the lesbian/gay/bisexual communities. She said she would also be the point person for AIDS with the Jordan administration. Ms. Harris apologized for the Mayor's inability to attend the meeting. She assured the Planning Council that the Mayor was very interested in its deliberations and would be sure to attend in the future.

Jon Dean Green spoke on the mandate given to Planning Councils by the Ryan White Comprehensive AIDS Relief Emergency (CARE) Act. The duties outlined in the legislation say the Planning Council shall: 1) establish priorities for allocation of funds; 2) develop a comprehensive plan for the organization and delivery of health services; and 3) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need. Mr. Green also referred to the conference language of the legislation which indicates the intent of Congress in establishing Planning Councils as part of the Act. "While the conferees have vested the authority to appoint such a council with the chief elected political official of the eligible area, we are equally committed to the fact that these councils are not advisory in nature or intent. The managers expect that the planning councils established under

this title be given full regard and discretion in executing their roles and responsibilities...Should the chief elected official of an eligible area not agree to abide by the established priorities, then the Secretary is instructed not to make funds available to the area..."

Dr. Hernandez followed up with a discussion on how the Planning Council had been formed, its collaborative nature, and how it worked in practice. Dr. Hernandez expressed to Ms. Harris the frustration of the Planning Council with the lack of overall AIDS planning in the City. Dr. Hernandez pointed to the desire of the Planning Council to be consulted in the deliberations by the Mayor's Office and the Board of Supervisors on AIDS services provision. The Planning Council had done extensive work to prepare itself for making funding priority decisions. The knowledge of the Planning Council, especially in regards to the San Francisco continuum of care and community needs was a resource to be drawn on.

b) CARE Plan for 1992

Dr. Sophia Chang spoke to the plan developed for 1992. The Planning Council has closely examined how services are delivered in the City and has defined the continuum of care for the "San Francisco model." The final form was one based on six service areas a) Case Management, Eligibility, and Advocacy; b) Housing; c) Primary Medical Care; d) Psychosocial Services; e) Other Primary Care; and f) Substance Abuse Services.

Dr. Chang next described the process for how funds are received and disbursed by the City. The Formula portion of CARE is just that. A formula is developed by the Health Resources and Services Administration (HRSA) that is dependent upon prevalence and incidence of AIDS cases and an award to the eligible cities based on that formula is made. The Supplemental portion of CARE is a competitive process wherein eligible areas submit proposals for funds based on need and ability to appropriately use funds.

The Supplemental portion of CARE is what complicates the planning process. Much of the work is frontloaded. When the Supplemental application goes to HRSA, it must contain not only the amount of funds that the City is requesting, but identify the service to be delivered and identify the contractor. What this effectively means is that a request for proposals (RFP) must be performed with no guarantee that grants designated for awards will actually receive funding.

Dr. Chang said that important part of the planning process for the City is the process itself. It was so proactive and exhaustive that at times a need was identified with no one able to perform the service e.g., probate conservatorship. The Planning Council's main source of information is the community it serves. The Planning Council is always turning to the various communities affected by the pandemic to see what the communities need.

Dr. Hernandez next pointed out, using housing and substance

abuse as examples, the failure of the federal government to provide adequate funds for those services was forcing dollars for AIDS services to make up the gap. This means that in those areas, there are the beginnings of a two-tiered system. One would be for those persons with HIV for whom treatment or housing slots would be available through AIDS dollars. The second would be for persons without HIV who, if they were without means to pay, would be forced to wait for services.

Dr. Hernandez then moved the discussion to two other important areas in the planning process. The first was that the Planning Council had tried to assure that services delivered with CARE funds were culturally appropriate and competent. The second was that the Planning Council had discussed in a number of different forums the copayment requirement of the CARE legislation. The Planning Council was cognizant of the fact that those persons who could afford to pay for services should pay for services. The model for San Francisco must begin to move away from free services. The discussion of copayment and how to move towards it is a tremendous amount of work. Dr. Hernandez said that this would be a subject the Planning Council will really have to struggle with. The worry is that 1992-93 will be the peak year of funding.

Mike Shriver pointed out to Ms. Harris that in terms of continued funding for CARE at the Federal level, San Francisco could do more work in the lobbying area. Mayor Jordan needed to make plans to attend the lobbying effort planned for May 5-7, 1992. Mr. Shriver pointed out that many perceived Mayor Dinkins of New York's discussion with the President on AIDS as being a primary reason the President had monies for AIDS marked up in his 1992 budget.

Estela Garcia informed Ms. Harris that there were various needs the City had. There are national needs and there are local ones. One of the local needs and problems has been the City's Civil Service. There is a good relationship between the Department of Public Health (DPH), AIDS Office and the Planning Council. The problem in working with the City was Civil Service. Civil Service did not seem to grasp that <u>emergency</u> funds should have <u>emergency</u> status. Ms. Garcia stated that the Mayor's Office needs to help Planning Council get the funds out so they can serve persons with HIV.

Pat Underwood underlined that one of the things the Mayor's Office could aid the Planning Council and AIDS Office with was evaluation. There is a 5% administrative cap on CARE funds. This small cap limits the ability to perform true evaluation. Without evaluation there is no way to tell if good money is being thrown after bad. Funds for evaluation that cannot be paid out of CARE funds could come from other sources.

Dr. Hernandez stated that the AIDS Office staff already works way over 100% of the time. What needs to be done with evaluation is contract out the service. DPH is both the grantor of funds and service delivery provider in some areas. Pierre Ludington made the point that as monies dry up, if the Planning

Council could evaluate, they would know what works, and what does not. This would allow the Planning Council to make difficult decisions with real information.

VI. CAEAR Update

Moved to next meeting.

VII. Use of One Time Funds

Moved to next meeting.

VIII. Review of CARE Application Process

Moved to next meeting.

IX. Public Comment

Three persons from Bay Positives spoke before the Planning Council on the work Bay Positives is doing. The consensus of the three was the need of youth for a sensitive environment in which to seek services. Many youth feel that they are not listened to when explaining their needs. The purpose of Bay Positives is to offer peer support to youth with HIV. Youth need youth based models to aid themselves. Many adult models do not work. The question was asked would it be helpful/necessary to have a youth as an advocate on the Planning Council? The answer was yes. The person who best knows the needs of youth is someone else who's young.

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HIV HEALTH SERVICES PLANNING COUNCIL

April 13, 1992
25 Van Ness
3rd Floor Conference Room
4:30 - 6:30 p.m.

I. Roll Call

II. Review and Approve Minutes and Agenda

III. Approval of Change in Units of Service
(Project Open Hand)

IV. DPH Personnel Hiring Update

V. CAEAR Update

VI. HUD Title VIII Purview

VII. Use of One Time Funds

VIII. Review of Care Application Process
a) One agency application per service area rule

IX. Public Comment

X. Agenda Development

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HIV HEALTH SERVICES PLANNING COUNCIL

April 13, 1992

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April 27, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL

May 4, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL

May 18, 1992

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HIV HEALTH SERVICES PLANNING COUNCIL
June 8, 1992
25 Van Ness, 3rd Floor Conference Rm.
4:30 - 7:30 p.m.

I.	Roll Call	
II.	Review and Approve Agenda and Minutes New Meeting Times	
III.	State Budget Update	4:45
IV.	Presentation by Mayor Jordan	5:00
V.	Use of One-Time Cost Savings	5:30
VI.	Title VIII HOPA Discussion a) Proposed Use of Funds b) RAS Information c) Dementia Care Needs	6:00
VII.	Requests for Change in Units of Service (Laguna Honda and Ward 86)	6:45
VIII.	Preparation for Year 02 Monitorings New Evaluations	6:55
IX.	Review of CARE Process Discussion on Development of Working Groups on Subject Areas	7:10
X.	CAEAR Funding	7:20
XI.	Public Comment	7:25
XII.	Agenda Development	

Please remember to bring all three sets of minutes included in this mailing.

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HIV HEALTH SERVICES PLANNING COUNCIL
June 8, 1992
4:30-8:00 p.m.

Members Present: Reggie Williams, Michael Baxter, Maria Church, Moher Downing, Marcy Fraser, Yvonne Frazier, Estela Garcia, Jaime Geaga, Les Hanson, Karen Hembry, Gifford Leoung, Steve Lew, Pierre Ludington, Kent MacDonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Sylvia Villareal, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Pat Christen, Gerald Lenoir, Darol Nance

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Jon Dean Green

I. Roll Call

Roll Call was taken as above. New members to the Planning Council were introduced.

II. Minutes

The agenda for the June 8, 1992, meeting and the minutes of April 27, and May 4 & 18 meetings were approved.

Sophia Chang proposed that the meeting schedule for the Planning Council be changed from its regular schedule of the second and fourth Monday of every month to every Monday from 4:30 - 7:30 p.m., due to the massive amount of work facing the Planning Council in the coming months. Dr. Chang reiterated to the Planning Council that it had made the decision that all services were to be rebid in Y03 of CARE. In addition, there is the possibility that funding will be held level or even reduced in Y03 due to the addition of six new Title I cities. The Planning Council, to prepare for Y03, must perform program evaluations, reprioritize the continuum of care, rebid all services and reformulate the strategy for HIV care in San Francisco.

A) The following motion was passed by the Planning Council:

> Starting July 29, 1992, the Planning Council's regularly scheduled meeting will be every Monday from 4:30 - 7:30 p.m.

Jon Dean Green discussed recommendations for new members to the Planning Council. Vacancies on the Planning Council that were either required to meet the mandates of Title II or as voted upon by the Planning Council were for representatives of

hemophiliacs and the unions. Mr. Green also raised the question as to whether it would be appropriate for the Planning Council to add a member whose expertise included Marin County, since the Planning Council currently had someone with expertise on San Mateo County.

The consensus of the Planning Council was to postpone decisions on new additions to the Planning Council until a later date.

III. Title II (Y01) Budget Revision Approval

Sophia Chang presented revisions to the Title II Y01 budget. San Francisco received $682,909 from Title II. Title II is the second portion of the CARE Act which provides funds to San Francisco County through the State of California, rather than directly from the Health Resources and Service Administration (HRSA).

Under Title II, $24,947 was allocated to San Francisco General Hospital (SFGH) to fund three months of the Minority Outpatient Project at SFGH. The Minority Outpatient Project had previously been funded under the HRSA Service Demonstration Project (SDP). The HRSA SDP programs were all being subsumed into CARE as part of the CARE Act legislation. SFGH's Minority Outpatient Care program supported salary for Dr. Eric Goosby, who had left to take a position with the Federal Government. DPH was unable to find a replacement in time to expend the monies and is requesting the Planning Council allow CPHS to use the funds for "as needed" physician time.

B) The following motion was passed by the Planning Council:

> To allow the Department of Public Health to use the unexpended CARE Title II monies of $24,947 for "as needed" physician time.

Dr. Chang next discussed the $98,089 allocated to VN&H for an augmentation of the Pilot Care Case Management Program. Due to errors involving both the DPH and VN&H, the money was unexpended and no rollover of funds was requested to the State. The $98,089 will have to be returned to the State to be used in the AIDS Drug Program (ADP). The AIDS Office is working in conjunction with its fiscal department to assure that a similar oversight does not reoccur.

Q-Why were the funds unexpended? A-Pilot Care is a nursing case management model funded through the State and HRSA. Due to late hires within the DPH, the loss of an AIDS Office nurse due to family illness, and accidental double billing by VN&H, the funds went unexpended. Dr. Chang stated that all patients registered in the Pilot Care program received all necessary services. No one was denied services, rather the AIDS Office was unable to enroll the originally estimated number of new patients into the Pilot Care program.

Planning Council members questioned how much of the AIDS Office oversight was due to the great number of contracts and limited

number of staff to perform administrative duties? Dr. Chang responded that due to delays in billing by contractors and the intricacies of Central Office Accounting, expenditure of funds is difficult to track. Several Planning Council members reiterated that the current trend in government was to underfund administrative positions to fund direct service positions. This created bottlenecks in the system and unmanageable workloads for extant staff.

IV. Presentation by Mayor Frank Jordan

Mayor Jordan began by complimenting the Planning Council on the work it has performed in the face of an extraordinarily difficult task. Mayor Jordan stated he is aware of the magnitude and urgency of the issues surrounding HIV facing San Francisco.

Mayor Jordan discussed the proposed 1992-1993 City and County budget. He stated that the budget for the DPH was crafted after lengthy meetings with the DPH, department heads, and providers. Facing a deficit estimated at $175 million, his administration attempted to preserve and expand AIDS/HIV services. To close the budget gap, Mayor Jordan proposed a one-year business utility tax, which the business community accepted. The strategy taken with the budget was to prevent any community from assuming a disproportionate share of the deficit.

Mayor Jordan next discussed his testimony before the Senate Subcommittee on Labor and Human Resources concerning the underfunding of the Ryan White CARE Act. (Text of the testimony distributed at the meeting.) Mayor Jordan felt that Elizabeth Taylor garnered the necessary attention of the Senate and the press for a demonstration of the urgency and necessity of full funding for the CARE Act. Mayor Jordan stated that he felt the Senate Subcommittee understood the urgency of the problem and the inability of San Francisco and other Title I cities to continue to carry the burden of providing HIV care with inadequate funds.

Mayor Jordan stated that his agenda is to help San Francisco and her citizens in whatever way he can. He stated he is aware that there are greater needs than keeping the Giants at Candlestick. Mayor Jordan said that San Francisco and the Planning Council are on the cutting edge of provision of HIV related services. The Planning Council and his administration must work together in confronting Washington and demanding further AIDS funding.

Bob Nelson congratulated the Mayor on his work in Washington. Mr. Nelson next asked the Mayor's assistance in speaking with Willie Brown concerning proposed State budget cuts in Sacramento and the maintenance of effort required under Title II for AIDS dollars and services. He also requested that the Mayor consider further funding of AIDS Office administration to allow the AIDS Office to better administer the funds. Mr. Nelson stated that the AIDS Office staff were markedly overworked.

Eric Rofes thanked the Mayor for his work in Washington. Mr. Rofes stated that the role of the Planning Council was planning, analysis and oversight of AIDS services in the City and County of San Francisco. Mr. Rofes requested the Mayor take advantage of the expertise represented in the Planning Council and its ability to see the larger picture in the provision of HIV services for San Francisco. Mr. Rofes stated he understood that politics sometimes played a part in various proposals by groups for HIV services, but to achieve a comprehensive and well planned continuum of HIV services, the Planning Council should be consulted to allow for global strategies and responses to service needs.

Mayor Jordan informed the Planning Council that he would be returning to the Capitol on June 16, 1992, for 2-3 days. He will be covering a wide array of topics while there. If the Planning Council felt that there were further efforts the Mayor could make while on this trip, it should let him know.

V. Use of One Time Funds

Sophia Chang presented the estimated Y01 Formula cost savings of $1.1 million. Dr. Chang stated that HRSA would allow rollover from Y01 to Y02 but not from Y02 to Y03. All funds for Y01 and Y02 must be fully expended or returned to HRSA. Dr. Chang outlined potential uses for one-time funds.

1) DPH was requesting $25,000 to cover proposed cost of Cost of Living Allowances (COLAs) to maintain the current level of staff.

2) Reinstituting program cut from the general fund budget i.e. 24 hour dementia care and probate conservatorship. There is currently no funds available for these services, and no provider identified.

3) Funding S.F. Suicide Prevention at its full request of $36,000 on the Supplemental Application. This is the last of the CBO programs with identified providers requested under the Supplemental Application that remains unfunded.

4) Youth services set aside in the Supplemental Application ($400,000) subsequently reviewed by RFP teams with recommendations of $236,367 in services.

5) DPH requests previously approved by the Planning Council at $256,129.

6) CBO one-time requests of $514,500.

7) Additional DPH requests of $252,377 for full funding of DPH requests.

8) A one-time consultant to institute the co-payment system necessitated by CARE.

Gifford Leoung asked if it was appropriate to begin programs such as youth services with one-time funds? Dr. Chang responded that since the Planning Council had made the decision to rebid all services in Y03 and level funding from HRSA was not assured, all funds should be considered one-time funds. Dr. Leoung next stated that he felt the co-payment system was of paramount importance in that the Planning Council had previously made the decision that those persons able to pay for service, should. Dr. Leoung stated that if the Planning Council did not take the step to fund a consultant to begin a co-payment system in Y02, the Planning Council would be unable to in Y03.

Jaime Geaga asked if the proposed percentage of funding for People of Color (POC) communities had been met. Dr. Chang responded that the Planning Council had met its mark. Pierre Ludington asked what types of services were requested under the CBO one-time requests. Jon Dean Green stated that one time requests fell primarily in categories such as housing vouchers, infrastructure support, computers, outreach, transportation, women's monolingual support groups, attendant care, and furniture and equipment.

Mike Shriver put forward the following proposal for the approximately $1.1 million in one-time savings:

DPH Request	256,129	
Youth Specific Expenditures	269,367	
Suicide Prevention Proposal	36,000	
CBO One-Time Requests by Priority	290,000	
SF DPH Remaining Requests	245,000	(or remainder of funds)

The Planning Council consensus was that the proposal was appropriate with the addition of the one-time consultant for a co-payment system. The consultant should be placed under the CBO one time requests, with the amount remaining to be used to cover the $25,000 of COLA shortfall for the DPH, the remainder to be used by the DPH to further fund DPH requests.

C) The following motion was passed by the Planning Council:

> That the estimated $1.1 million in one-time cost savings should be allocated as follows: a) DPH priority request ($256,129); b) Youth specific programs ($269,367); c) S.F. Suicide Prevention ($36,000); d) CBO one-time expenditure requests ($290,000); e) Consultant for co-payment system ($100,000) and f) DPH additional requests ($25,000 for COLAs for existing contracts and $123,504 for further requests.)

VI. Title VIII HOPA Discussion

Bill Haskell, AIDS Office, reiterated his previous discussion on HOPA funds. The San Francisco EMA expects to receive approximately $4.1 million in HOPA funds. 86% of the funds will

remain in the City and County, with 7% going to San Mateo and 7% to Marin. The regulations are expected to be released on June 30, with applications due in late July or early August. The Planning Council had at its last meeting prioritized: 1) Permanent Housing, 2) Transitional Housing, and 3) Short Term Housing. Mr. Haskell requested the Planning Council to provide further guidance in regards to the percentage split of capital expenditures v. non-capital expenditures.

Mike Shriver reminded the Planning Council that the HOPA funds were for housing only, and requested Planning Council members to be mindful of conflicts of interest. Mr. Shriver stated there is a fine line between technical assistance and conflict of interest that Planning Council members must not cross over.

Mr. Haskell presented a summary of monies allocated to date for lease and subsidy programs in Y01 and Y02 of CARE. In Y01, 25 units/104 beds were leased at a total cost of $355,433. Y01 subsidies cost $340,120. In Y02, 76 units/174 beds were leased at a total cost of $827,412. Y02 subsidies cost $677,182. Mr. Haskell stated that if CARE funds were to terminated most of these housing programs would cease to exist.

Carol Anderson, Corporation for Supportive Housing, made a presentation with 3 different scenarios for what the Planning Council could conceivably buy with its funds. Scenario one was 100% allocated for capital expenditures, scenario two was 75% capital expenditure 25% subsidy/lease mix, and scenario three was a 50/50 split between capital expenditures and subsidy/lease. Ms. Anderson stated that until the regulations are published, the allowability of providing security deposits and the maximum length of rent subsidies is unknown. Pierre Ludington asked what would be the operating cost for scenario one, a 50 bed single room occupancy (SRO) hotel? Ms. Anderson responded that it would depend. The usual cost for operating expenses is $250-280/unit/month. ($150,000 for a 50 unit SRO.) The operator of the facility could apply for Section 8 subsidies. Under Sec. 8, the government pays operating costs and residents are required to pay 30% of their income for rent.

Bill Rumpf, S.F. Redevelopment Agency, next spoke on the timeline for development of housing. An optimal timeline for a project would be 10 months to one year to: Advertise the Notice of Fund Availability, make funding decisions, acquire property, prepare plans, obtain permits and rehabilitate property. Mr. Rumpf stated that for Hospice by the Bay's Leland Avenue residence, the process will take 2 years from negotiations with the owners to occupancy of the building. This timeline is longer in that it included time required to combine several sources of funds.

Q-Is it realistic to expect a pool of organizations ready to take part in any HOPA projects? A-Yes. The Redevelopment Agency's purpose is to help agencies decide on whether they want to acquire properties. A meeting is being convened of the Council of Community Housing Organizations. Q-Is the timeline

presented strict? A-No, it is based on getting the monies into the community as quickly as possible. Q-Can these funds be used to support families? A-Probably. Group homes would be a setting that could support families. Q-What would the Americana Suites be worth if it were to be purchased? A-Buying is serendipitous. The Americana is worth between $2.8 - 3.8 million and has 75 units and commercial space. The average cost for a unit on Turk is $20,000/unit and $35,000/unit for a nicer tourist hotel. Q-What parameters are needed by the Redevelopment Agency to move forward? A-Guidelines for how much for subsidies and how much for acquisition and development. Q-What input does the Planning Council have in the decision making process for these funds? A-Technically, the Redevelopment Agency is the "lead agency." The Redevelopment Agency is looking to the Planning Council for guidance. The loan committee for the Redevelopment Agency normally consisting of Kent Simms, Director of the Mayor's Committee for Economic and Community Development; Edward Helfeld, Director of the San Francisco Redevelopment Agency; and Ted Dientsfrey, Director of Housing and Community Development; has been expanded by four people with HIV expertise: Patricia Underwood, Marcy Fraser, Larry Cruz and Bill Haskell. The process would be that the loan committee recommends and the Planning Council approves recommendations.

Mary Jo Buerger, Marin County, stated that the HOPA process for Marin was similar to San Francisco's. Marin is calling together HIV and Housing service providers to prioritize usage of funds and make decisions on acquisition v. rent.

The consensus of the Planning Council was to meet on June 15, 1992, to finish prioritization of HOPA funds.

VI. Requests for Change in Units of Service

Valerie Dorr, AIDS Office, presented three proposed changes in units of service with DPH Memoranda of Understanding.

The first was by SFGH. SFGH requested to be allowed to decrease unduplicated clients (UDC) from 1000 to 800, and units of service (UOS) from 1000 encounters to 800 encounters. The primary reason for the decrease was lack of space and support staff. SFGH did not have the physical space to see these additional patients.

The second request was from Laguna Honda Hospital (LHH). LHH is requesting to go from 200 UDC to 25 UDC and 1316 UOS to 350 UOS, with a subsequent reduction in money from $100,000 to $26,600. The change in funds is commensurate with the requested change in UOS. The reason for the requested change is the lack of admissions into the program after an agressive recruitment campaign. Persons seeking respite care would be referred to the CARE funded VN&H respite program (also currently under utilized) if services were unavailable at LHH.

The third request was from Maternal and Child Health (MCH). MCH

is requesting a reduction in unduplicated clients from 80 to 50. The reason for the requested change is that with the number of hours of staffing, MCH would only be able to provide 8 hrs./client/year. Under the change, MCH could provide 13 hrs./client/year.

D) The following motion was passed by the Planning Council:

> To allow the requested UDC and UOS changes by SFGH, LHH, and MCH.

Sophia Chang reminded the Planning Council that at the next meeting, the monitoring and evaluation process must be re-examined. Decisions on funding will be made on the evaluations. The Planning Council will be called to make hard decisions because of potential funding short falls in the coming year(s). Without a good tool to evaluate programs, the Planning Council will not feel comfortable with its decisions. The Planning Council must invest time in designing a strong tool to make these difficult decisions.

HIV HEALTH SERVICES PLANNING COUNCIL

June 15, 1992

The Agenda of this meeting is missing.

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HIV HEALTH SERVICES PLANNING COUNCIL
June 15, 1992
4:30 - 6:30 p.m.

Minutes

Members Present: Reggie Williams, Michael Baxter, Maria Church, Yvonne Frazier, Estela Garcia, Kent Macdonald, Scott Miller, J.B. Molaghan, Eric Rofes, Mike Shriver, Laura Thomas, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Pat Christen, Moher Downing, Marcy Fraser, Jaime Geaga, Lester Hanson, Karen Hembry, Gerald Lenoir, Gifford Leoung, Steve Lew, Pierre Ludington, Darol Nance, Bob Nelson, Elliot Ramos, Pat Underwood, Sylvia Villareal

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Jon Dean Green

I. Roll Call

Roll Call was taken as above. A quorum was not present.

II. Review and Approval of Minutes and Agenda

Approval of the minutes of the June 8, 1992, meeting were deferred to the June 22, 1992, meeting.

III. Title VIII HOPA Parameters

Bill Haskell, AIDS Office, stated that according to AIDS Action Council, regulations for HOPA funds were being delayed by the Office of Management and Budget (OMB). The new estimated date for the release of HOPA regulations is July. Applications will be due in September. Applications will be reviewed by the Department of Housing and Urban Development (HUD) as they are are received. Q-When will the money be available to San Francisco? A-Originally, it was expected that monies would be available 30 days after the issuance of the regulations. Realistically, it may not be until the Fall.

Mr. Haskell reviewed two different areas of AIDS Housing: 1) Residential AIDS Shelter (RAS) Programs and 2) 24 Hour Dementia Care.

San Francisco currently has four RAS facilities. The first, Missionaries of Charity's "Gift of Love" facility, is a 16 bed site that is covered by RAS licensure exemption, but receives no State funds. The second, at San Francisco AIDS Foundation, is an 8 bed facility funded directly through the State at $46,778.

The third and fourth facilities are funded by the State through the Department of Public Health (DPH) and consist of a) Catholic Charity's "Rita da Cascia" facility, an 8 bed site, funded at $46,778; and b) Shanti Foundation's 5 bed site, funded at $40,000. Mr. Haskell stated that the State Office of AIDS (OA) has not at this point indicated any cuts in funding for RAS programs. In light of the uncertainty of the State budget, this may change. Assemblywoman Barbara Friedman has introduced AB2266 to extend the RAS legislation from July 1993 to July 1995. Without legislative extension, current programs are slated to end after the 92-93 fiscal year.

Mr. Haskell next discussed 24 hour dementia care. Originally, monies were set aside from the General Fund to pay for dementia care for persons with moderate dementia. Since this program was not in development during the last round of General Fund budget cuts, it was defunded. Currently, there is no funding for the project, and no operator identified to operate this type of facility. Reasons for the lack of an operator include new licensing requirements, and questions concerning the adequacy of funds from the original RFP developed in May, 1990. This type of program could conceivably be funded with HOPA monies.

Bill Rumpf, S.F. Redevelopment Agency, answered a question from the June 8, 1992, meeting: "What agencies currently have housing developments in the pipeline?" Mr. Rumpf stated that there are two projects that are in process: a) Hospice by the Bay's Leland Ave project, and b) Hope House. There are another two projects in predevelopment: a) CURAS is proposing a 10 bed group home in the Mission district, and b) Shanti is proposing a 65 unit facility at the Americana Suites site.

Although there was no quorum present to vote on any proposals in regards to guidance for the Redevelopment Agency in preparation for the application to HUD, Sophia Chang asked the members present to discuss the matter and make a recommendation to the full Planning Council for consideration. Dr. Chang reminded the members present that with 6 meetings upcoming concerning the service subject areas and the overall continuum of care, in addition to monitorings and evaluations of Y02 projects, the Planning Council needed to move forward with HOPA and then on to other projects.

Kent Macdonald distributed a rough draft for proposed guidelines for the Redevelopment Agency on usage of HOPA monies. Mr. Macdonald stated that given the unknowns of service needs, lack of HOPA regulations etc., flexibility is needed. He recommended that the Planning Council develop standards for the Redevelopment Agency and have the Redevelopment Agency gauge and evaluate proposals by these standards.

Bill Rumpf indicated that guidelines of this sort would be helpful, but that the Redevelopment Agency also needed input on the amount of funds that the Planning Council wants spent on capital expenditures for acquisition i.e. most/one-half/some.

In reference to the draft presented by Mr. Macdonald, several Planning Council members expressed concern over language prioritizing small projects over large projects, and the lack of gay men, families and women with children in the target populations. There was consensus by the Planning Council that the first priority should be those persons most critically in need of housing due to homelessness or risk of homelessness. Scott Miller indicated that rather than using "youth" as a generic term, adolescents and young adults might be preferable.

Estela Garcia stated that she would like the members present to discuss the amount of funding that would go to capital acquisitions v. subsidies/leases. Ms. Garcia asked the Planning Council to consider a 75/25 split between acquisition v. rent. The question is does the Planning Council prefer that the bulk of the funds go to acquisitions or rent?

Sophia Chang pointed out that the Planning Council can indicate the approximate percentages for acquisition v. rent and use the draft from Mr. Macdonald as the philosophical standards for proposals.

Mary Jane Wood stated that her priority would be for the bulk of the funds to be used for acquisition of property. With CARE monies not allowing capital expenditure, this was the only source of funds for the Planning Council to acquire housing, v. renting housing.

Yvonne Frazier stated that if substance users are a target population, then the Planning Council must consider sober housing v. a substance usage environment at some point, but that in regards to percentages, she favored the 75/25 split.

Estela Garcia stated that she had proposed the 75/25 split for the sake of discussion. Ms. Garcia also asked for a full discussion on the long and short term implications of such a split on housing services in the City. What are the gains v. the consequences.

Bill Haskell stated that two ramifications come easily to mind. The first is that with a 75% goal for capital acquisitions, it sends a message to AIDS Housing providers that there are new options for providing housing in San Francisco. The second is that it would allow agencies to move monies from leasing housing to purchasing housing. This might free up some housing monies to be used for other services. If CARE monies are reduced in future years, housing would be less effected with expenditures on acquisitions which would not require year to year allocations of uncertain funds. A disadvantage would be the time required for start-up. It is a long term investment.

Sophia Chang pointed out that with the acquisition of housing, housing can be assured for the next 5/10/15 years, versus only knowing the amount of funds for housing for next year. Q-How would overhead be covered? A-As Carol Anderson pointed out, overhead could be covered through rent charged on the units.

Ellen Hartke, Housing Coordinator-Shanti Project, pointed out that the great need for emergency housing in San Francisco is aggravated by the lack of permanent housing available. People remain in emergency housing because there is no place to refer them to. If monies continue to be primarily for emergency housing, there will always be a need for emergency housing.

Bill Rumpf indicated that the criteria normally used by the Redevelopment Agency to evaluate a project include: a) Cost effectiveness (cost per bed per client), b) Capacity of sponsor (organization's ability to raise money, operate program), and c) Mixing populations (integration) v. specific housing. Mr. Rumpf also indicated that rather than considering the size of the facility, he would recommend examining cost v. building size.

Q-Does the Redevelopment Agency have a maximum dollar amount award? A-No. The Redevelopment Agency examines the range of proposals. Q-Must the residence be physically located in San Francisco v. serving S.F. residents only, someplace else (similar to The Redwood Center in San Mateo)? A-Don't know.

Sophia Chang recommended that questions concerning integration of service be put to the HIV Housing Network. It has the expertise to better understand AIDS specific housing v. integrated housing. Estela Garcia also recommended that the Redevelopment Agency hold a public hearing for consumer input.

The consensus of the members present was that a 75/25 split should be recommended to the full Planning Council, the HIV Housing Network should be asked concerning integrated housing, and the Redevelopment Agency should hold a public hearing for consumer input.

IV. Preparation for Y02 Monitorings

Sophia Chang informed the Planning Council that CARE monitoring protocols would be sent to agencies on July 20, 1992. The Subcommittee on Evaluation is being reconvened. The Subcommittee is examining how to evaluate programs, criteria to be used and how to maintain overall evaluation consistency. There are two different types of programs to be monitored and evaluated: a) Continuation programs from Y01 to Y02, and b) New Supplemental programs for Y02. The evaluation for the new Supplemental programs will be a start up evaluation only. In the revamping of last year's monitoring tool, there are several changes: a) the AIDS Office will examine grading criteria for the various pieces of the monitoring tool, b) AIDS Office staff will write all reports, c) a training for Planning Council members will occur during a Planning Council meeting, d) a training will be held for contractors in how to respond to the protocol.

The next meeting of the Subcommittee on Evaluation will be Friday, June 19 at 3:00 p.m. at the AIDS Office. All Planning Council members are encouraged to attend.

Eric Rofes expressed several concerns. Different teams evaluated similar situations differently. There must be consistency and equity in evaluation. Different programs were held to different standards i.e. large agencies/small agencies, new agencies/old agencies, agencies serving primarily gay white males/people of color/women. Mr. Rofes asked that AIDS Office staff members be charged with maintaining equity and consistency of reviews.

Sophia Chang stated that a goal of the change in protocol and system was to prevent evaluations from being arbitrary. If the teams are consistent in their manner of evaluation, the team will not need to make recommendations on continued funding. The Planning Council can set a standard of evaluation and all agencies/programs falling below that standard would be considered for defunding. The process will be as follows: 1) written protocols will be sent to agencies; 2) a training will be held for contractors on the protocol; 3) the responses to the protocol will be sent to review teams' 4) review teams will site visit programs; 5) at the end of the site visit, the team will discuss their evaluation and make recommendations; 6) a report is generated by the AIDS Office staff; and 7) a summary of recommendations and evaluations will be presented to the Planning Council.

J.B. Molaghan suggested that teams from Y01 be reconstituted if possible. The members have background and familiarity with the agencies/programs.

Valerie Dorr distributed a listing of CARE contracts. Ms. Dorr asked Planning Council members to indicate agencies they wished to review, conflicts of interest and potential community members for the review teams. Sophia Chang stated that conflicts of interest were the most important piece to indicate.

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HIV HEALTH SERVICES PLANNING COUNCIL

June 22, 1992
25 Van Ness, 3rd Floor Conference Room
4:30 - 7:30 p.m.

Agenda

I. Roll Call

II. Approval of Agenda and Minutes

III. Title VIII HOPA Parameters

IV. Preparation for Y02 Monitorings

V. Tite II Y01 Rollover Funds

VI. Review of Citywide Primary Medical Care Programs

VII. Title II Maintenance of Effort

VIII. Planning Council Membership

IX. CAEAR Funding

X. Public Comment

XI. Agenda Development

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HIV HEALTH SERVICES PLANNING COUNCIL
June 22, 1992
4:30 - 6:30 p.m.

Members Present: Michael Baxter, Pat Christen, Estela Garcia, Jaime Geaga, Lester Hanson, Karen Hembry, Pierre Ludington, Kent Macdonald, Scott Miller, J.B. Molaghan, Darol Nance, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Sylvia Villareal, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Reggie Williams, Maria Church, Marcy Fraser, Yvonne Frazier, Gerald Lenoir, Gifford Leoung, Steve Lew, Bob Nelson

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Joe Jung, Jon Dean Green

Interpreters: Chris Clephas, Catherine Anderson

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I. Roll Call

Roll Call was taken as above.

II. Review and Approval of Minutes and Agenda

The agenda of June 22, 1992 and minutes of June 15, 1992 meeting were approved.

III. Title VIII HOPA Parameters

Sophia Chang recapitulated the June 15, 1992, Planning Council discussion of HOPA parameters and the consensus that a split of 75%-25% be the target goal for capital expenditures v. rent/lease expenditures. Dr. Chang also referred the Planning Council to the draft "Recommendations for AIDS Housing Opportunities Act Funds Allocations" (Recommendations) prepared by Kent Macdonald. Revised Recommendations were handed out by Mr. Macdonald. The Recommendations were intended to be used by the Redevelopment Agency as the philosophical guidelines for HOPA funding.

Pat Christen asked about the reasoning behind the 75/25 split. Estela Garcia explained that she had originally proposed the 75/25 split as a basis for discussion on the long term impact of purchase v. lease. The discussion held by the Planning Council was on long term v. short term gains for persons who were homeless or at risk of homelessness. Dr. Garcia stated that the Planning Council was aware that capital expenditures would be time intensive, with up to two years required for development. However, with purchased housing, housing needs would not be dependent on year-to year funding. The consensus of the members

at the June 15th meeting was to prevent a perpetuation of housing unit shortage. The Planning Council recognized that people have long term needs that are often not met by stays in emergency housing of 30-90 days.

Kent Macdonald explained that the Recommendations were formulated with the idea that the Redevelopment Agency should use maximum flexibility in the evaluation of proposals to HOPA's Notice of Fund Availability. Mr. Macdonald explained that under Recommendation 3, the third paragraph should be considered a basis for Planning Council discussion.

The consensus of the Planning Council was that the HOPA expenditure parameters and Recommendations should be postponed for discussion to the June 29, 1992, Planning Council meeting.

IV. Preparation for Y02 Monitorings

Jon Dean Green announced that the Subcommittee on Evaluation had been reconvened and would be meeting on a weekly basis. The Subcommittee was examining and revising the monitoring protocol. Members of the Planning Council were urged to contact Jon Dean Green or one of the current members of the Subcommittee: Yvonne Frazier, Estela Garcia, Karen Hembry, Mary Jane Wood, Sylvia Villareal, and Bob Nelson.

V. Title II Y01 Rollover Funds

Discussion was postponed to the June 29, 1992, meeting.

VI. Status of the Proposed CDC Change in AIDS Definition

Dr. Raymond J. Baxter, Director of Health, met with the Planning Council to discuss recommendations the Planning Council might have for the Department of Public Health (DPH) and the City and County concerning the Centers for Disease Control (CDC) proposed change in AIDS Case Definition and its indefinite postponement/disapproval. Dr. Baxter stated that his most recent information was Dr. Mason, Director of the CDC, was recommending to Secretary Sullivan, Health and Human Services, that the proposed change in AIDS case definition be disapproved. Dr. Baxter indicated that certain localities in California (i.e. San Diego and Los Angeles) were interested in pilot testing the proposed case definition.

Pierre Ludington stated that he felt Dr. Mason's desire was to move towards mandatory HIV reporting. Mr. Ludington indicated that this was completely unacceptable and San Francisco must take a stance against mandatory reporting. He expressed his concern that if HIV results were reportable, numerous people would refrain from being tested.

Laura Thomas stated that even though she is very unhappy with the inadequacies of the proposed case definition, it was at least movement towards a better definition. Ms. Thomas agreed with Mr. Ludington that HIV reporting must not occur. She suggested that San Francisco pilot a project around a more disease based definition that would include concerns for manifestations found in women and Injection Drug Users (IDU).

Eric Rofes express his concern that while the proposed change of definition and its implementation date of July 1, 1992, had received wide press coverage, the delay/disapproval of the change had not. A number of HIV+ individuals and physicians were under the impression that the definition change had occurred and were already seeking services available to persons with an AIDS diagnosis. Mr. Rofes stated that the disarray in CDC over the proposed change was another example of CDC acting not only as a barrier to services but also a source of confusion. He stated that San Francisco must oppose HIV reporting.

Scott Miller spoke on HIV reporting being put to the California electorate. The electorate had clearly spoken with a decisive voice to repudiate HIV reporting. This message is one that needs to be reconveyed to the CDC.

J.B. Molaghan stated that for health care providers it is difficult to ignore the fact that persons with CD4 counts ‹200 have multiple health events, even if there has been no clinical manifestation under the current AIDS diagnosis definition. It is a disservice to ignore the needs of HIV+ individuals who are symptomatic but have not yet presented with an AIDS diagnostic manifestation. A more functional based definition is needed so that persons who are ill may be better served. The City and County must advocate for persons who are ill but do not meet the AIDS case definition.

Mike Shriver spoke on the political/economic ramifications of withdrawal of the change in definition. If the change had been implemented, there would have been a doubling or tripling of AIDS cases nationwide. This would have pushed up the number of Title I cities to almost 40 in Y04. More monies would have been called for under the Ryan White CARE appropriation. If there is no change in definition, the number of Title I cities remains much more stable.

A) The following motion was passed by the Planning Council:

> That the City and County of San Francisco should a) advocate for a more complete AIDS case definition, b) reject any call for reallocation of monies away from prevention and/or health services to support surveillance, and c) reject and oppose HIV reporting.

VII. Review of Citywide Primary Medical Care Programs

Sophia Chang reminded all presenters of the intent of the presentations, namely to inform the Planning Council of extant or in development primary medical care services for persons with HIV disease in the City and County of San Francisco. The intent of the presentations is not to discuss gaps in service or advocate for further funding though they could be alluded to. Dr. Chang stated that the Department of Public Health would present first, with private sector and community based organizations following.

Please note: Presentations based on summary handouts will not be recapitulated, only referred to.

San Francisco General Hospital
- a) Overview-Diane Miller, M.P.H.
- b) Inpatient Services-Anne Hughes, C.N.S.
- c) Ward 86-Jim Kahn, M.D.
- d) HIV/IVDU Clinic-Jeff Burack, M.D.

Diane Miller/Overview

(Please refer to enclosed handout.)

Ms. Miller stated that an African American woman has been identifed to take Dr. Goosby's place in the Minority Outpatient Program.

Q-What portion of services is uncompensated/uninsured care?
A-For inpatient services, it is a low number. For outpatient services, approximately 31% of patients are medically indigent.

Anne Hughes/Inpatient Services

Ms. Hughes began by stating that for many HIV+ individuals, hospitalization is a rite of passage. The hospitalization often leads to an AIDS diagnosis. As a nurse, it is very clear that sicker patients are being admitted. Many patients have never had an HIV test before admission, are lost to follow up, and often have no primary care provider. There is no relationship between the patient and a care provider. This leads to situations where a patient presents with PCP, is intubated and subjected to life support, without SFGH personnel knowing if this is how the patient would like to be treated.

There are 20 beds on Ward 5A. There are usually another 20 persons scattered throughout the hospital medical/surgical wards. Of the scattered beds, 10-20% are on psych wards. On the AIDS unit, patients are sicker, yet nursing hours have not changed. The hospital has been trying to struggle with a health care system in crisis. Another struggle faced by SFGH has been the inpatient census of 10-15 patients with CMV. It is hard to teach patients how to manage their infusion therapy. SFGH has been working with patients on infusion therapy, without reimbursement, to assure quality care. DPHG induction on an

inpatient basis has been denied by MediCal reimbursement for over a year. Services provided or to be provided by CARE monies are: infusion therapy, substance abuse consultants, psychiatric services, and an on-call AIDS consultant for nurses and house staff. Demographics for May, 1992, were: 98 medical/surgical; patients 92 men, 6 women; 62 white, 24 African American, Latino 11, Thai 1; risk categories were gay/bi 43, IVDU 14, gay/IVDU 33, heterosexual 5, unknown 3. Readmission within three weeks occurred in 15 of the 98 patients. Of the 98 patients, 7 were homeless, 5 had dementia, 40 have a history of current substance abuse. 91 patients were covered by MediCal or had MediCal pending.

Q-Why the high readmission rate? A-SFGH is not sure of all the co-factors. For many though, housing is a primary issue.

Jim Kahn/Ward 86

(Please refer to enclosed handout.)

Jeff Burack/HIV IVDU Clinic

Dr. Burack began by elucidating the basic conflict in the models of care for substance abuse patients v. care for patients with HIV disease: if a patient with HIV disease gets worse, you admit them; if a patient with substance abuse gets worse, you discharge them. The model for substance users with HIV is based on the fact that if primary care is provided at the substance abuse treatment site, follow up care for medical problems improves. 70% of the patients seen on the HIV IVDU ward are on methadone maintenance; 40% are women; over 50% are African American and Latino. The level of acuity of HIV disease has steadily increased. Staffing is .5 FTE physician time (1/2 day 5 days a week) and 1 FTE nurse practitioner. The facility for care is a 10 ft x 4 ft room. Ward 93 is attempting to provide full primary care. Patients are connected with social service, psych, and where appropriate women's clinics, for routine and acute care. There is a tuberculosis TB nurse on site to manage and dispense medications. Ward 93 uses Ward 86 extensively. For many patients, Ward 93 provides the only access to clinical trials.

Problems/limitations faced by the Ward 93 are the lack of: methadone maintenance slots, long term treatment for speed and cocaine addicts, and availability of opiate treatment. Two additional limitations are space and personnel. The clinic would like to extend the dosing hours, but does not have the personnel available to do so. There are approximately 125-130 clients receiving treatment from Ward 93.

Community Public Health Service (CPHS)

Gerry Oliva/Acting Deputy Director

(Please refer to enclosed handout.)

Dr. Oliva gave an overview of CPHS. Dr. Oliva stated that until three years ago, CPHS did not provide primary medical care services. Most of the health centers were the equivalent of well baby clinics. Health centers only performed screening and referrals. A tremendous transition continues to occur. Staff had to be retrained from prevention services to primary care, including caring for chronically ill patients. Phones, management information systems and billing all needed to be put in place.

Peggy Trezavant/Tom Waddell Clinic

Ms. Trezavant stated that previously, Tom Waddell had been the central emergency unit, providing care for the Tenderloin area. The current target of Tom Waddell is homeless patients. In 1987-88, when there were two treatment rooms, Tom Waddell began to provide primary care to the homeless. An outpatient clinic was established at the Ambassador Hotel. Currently, Tom Waddell provides 40,000 client contacts per year. Tom Wadell performs a unique service for the homeless, who have an array of problems and needs. Self care for this population is difficult with no permanent shelter or food.

Community Health Outreach Workers (CHOWs) who have experience with substance abuse and homelessness provide case findings, transportation, follow up and outreach. The CHOWs help in dealing with a population with trust issues around treatment.

The focus of Tom Waddell has gone from urgent care (episodic) to primary care. Client care is usually drop in. Clients are often so disorganized due to mental health and substance abuse issues that the only time they access medical care is when they are too ill to meet their other needs. There are 4 HIV clinics, with 3 providers each. An HIV team goes to hotels as needed. There are three general medical clinics for: a) Latinos, b) substance users, and c) women.

Judith Hager/Health Center #1

(Please refer to enclosed handout.)

Deborah Brown/Health Center #1

Dr. Brown spoke on how Health Center #1 reflected the demographics of the communities it serves--the Castro and Mission. Of the seven providers on staff, all are passably bilingual in Spanish/English. Patients are assigned to a primary provider to develop long term relationships with the provider. 70% of patients seen have complicating mental health and drug use histories. This makes treatment and care taxing. As clients become increasingly ill, appointment time increases. Patients with no insurance and no MediCal must go to SFGH for lab and pharmacy services. Health Center #1 previously had a contract with a private lab for medically indigent adults. There is no longer funding for this program. Health Center #1 providers go on hospice rounds, perform home visits and take

part in drug trials.

Q-How many support staff does Health Center #1 have? A-Currently, there are 5 RNs, the sixth was lost to early retirement. There are 5 health workers. Support staff is a problem. There are not enough people to do charts, answer phones, perform workups etc.

Q-Are there phlebotomy services at Health Center #1? A-No. Nurses perform some blood draws. There are no T-cell tests. Health Center #1 is trying to get a phlebotimist, but there is an issue of space.

Paul Gibson/City Cliinic

(Please refer to enclosed handout.)

Q-Is the age range of 20-29 arbitrary? A-No. City Clinic has never seen anyone <20.

Estela Garcia asked Dr. Oliva and the Health Centers to further document information presented by several presenters. Namely, that a number of clients being seen had never had a primary care provider, or accessed the health care system. Dr. Garcia stated there is a myth of reduplication of service within the City that documentation of first time clients could dispel.

Melissa Welch/Health Center #2

(Please refer to enclosed handout.)

Dr. Welch stated that Health Center #2 has the capacity to serve more persons with HIV disease who are within the catchment area. She is confident that the services at Health Center #2 are up to the challenge and Dr. Welch is working hard at increasing the number of HIV infected clients served.

Q-(To Dr. Oliva) The issue of the lack of space at Health Center #1 had supposedly been addressed by the Health Department, where does it stand? A-Health Center #1 is currently undergoing renovations to allow it to see more patients. There is also capacity at other clinics for patients with HIV. DPH is attempting to alter the pattern of care. Patients need to be educated on their options of places for care.

Dr. Oliva stated that the next two clinics to make presentations: Potrero and Southeast had previously been federally funded clinics, but are now part of CPHS.

Michael Drennan/Potrero Hill Health Center

(Please refer to enclosed handout.)

Dr. Drennan stated that Potrero has the capacity to see two to three times as many HIV infected clients as it currently does.

Eric Rofes stated that capacity at health clinics other than Health Center #1 and Tom Waddell was reassuring. It did not address the issue that had previously concerned the Planning Council of a lack of sensitivity to gay clients and at times exhibition by clinic staff of outright homophobia. Jerry Windley added that many persons in the community, including himself, did not know of the availability of quality services to be had at sites other than Ward 86 and Health Center #1. Gerry Oliva stated that DPH was currently putting together a brochure of services available at the different health centers. There will be outreach done to the community and education on the competency of clinic staff. Dr. Drennan reminded the Planning Council that most of the physicians at the various health centers had been trained in the same place that Ward 86 and Health Center #1 physicians had been--SFGH. Mr. Rofes stated that homophobia and sensitivity to the needs of gay men was still an issue. Sylvia Villareal stated that while the doctors might be sensitive, persons seeking care had to see clerks, nurses and support staff to get to the physician. The support staff (billing, eligibility, and nurses) are the make/break point for most clients.

Jay Stark/Southeast Health Center

(Please refer to enclosed handout.)

Dr. Stark stated that currently Southeast is seeing approximately 40 HIV infected clients. He expects that number to double. Of the clients currently being seen, 15 are IVDUs, 14 are women. 60-70% of the clients have CD4 counts <500. 5-10% have CD4 counts <200. Dr. Stark stated that it is a point of pride to the clinic that they have a feeling of family. Clients and providers are very attached to one another.

Q-What is the cap on clients? A-There is no cap. Southeast has the ability to see many more clients.

Nicki Collins/Special Programs for Youth

(Please refer to enclosed handout.)

Q-Does AZT interact differently with substance users in youth than it does in adults? A-Unknown.

Art Back/Public Health Laboratory

(Please refer to enclosed handout.)

Q-Does the public health laboratory perform T-cell testing? A-No. It does not have the technical expertise or equipment. The lab would be willing to, if it was given the request and the funds. Dr. Back recommends that since SFGH has the ability, augmenting its services seems more appropriate. Q-What needs are not being met for the laboratory. A-It is unable to respond

to TB in persons with HIV adequately. Dr. Back stated that he is not just referring to multi-drug resistant TB, but regular TB also. The case counts are increasing. The lab is developing the ability to perform rapid testing.

Rinna Flohr/Department of Mental Health

Mental health is providing a two pronged service approach for persons with HIV disease. The first involves serving people with HIV through existing services. The second involves providing special services with special expertise by consultants to the system as a whole. Mental Health serves the severely mentally ill client. One of the goals of the programs run by Mental Health is to divert clients away from Psychiatric Emergency Services. Services provided include: inpatient, outpatient, day treatment, residential care, aftercare, long term care, and locked facilities. Special services tailored to the needs of the mentally ill with HIV include: Peter Claver (8 beds out of 32, for patients with pre-existing mental illness and HIV and/or dementia); Continuum (40 slots of adult day health care); Chateau Agape (15 beds of a 30 bed dual diagnosis facility); Mission Crisis (mental health crisis services); Health Center #2(outpatient and case managed mental health); St. Mary's Hospital (mental health services targeted to African Americans); and the Center for Special Problems (victims of sexual abuse, transgender populations, criminal offender populations, sexual minority youth, severely mentally ill assaultive clients.) Mental Health is working with CURAS to target the Latino community.

Services being provided at Mission Crisis are for pschologically disabled clients in crisis. The goal is to reach clients before psychiatric emergency services are needed. Mission Crisis CARE monies have served 30 unduplicated clients, with a capacity for 185. The units of service provided to date are 600, with an anticipated 860/year. Originally, Mental Health estimated 1-10 encounters per client. Realistically, it appears 1-20 visits may be necessary. Client demographics are: 85% between 30-45; 60% are gay white males, 40% are gay Latino males; there is a 50/50 split in transmission category between gay/bisexual and gay/bi IVDU; 60% have an alcohol/drug abuse history; 50% have pre-existing mental illness and 50% are in crisis due to HIV. The source of referrals is CBOs 30%, SFGH 15%, Health Centers 40%, and privately referred 15%. Most of the clients live alone (which implies they have little in the way of an in-house support system), 10% live with a lover/spouse and 20% live with friends. Mission Crisis is currently not seeing any homeless. Medical history for patients is: 10% with dementia, 30% with disabling HIV and 60% with AIDS. The demographics reflect the Mission Crisis' program target population. There are four staff people funded: .5 FTE SW, .25 FTE health worker, .75 FTE Health Program Coordinator, and a .75 RN. The program "bootlegs" physician services. It uses the on-call doctor system. This is problematic in that there is no continuity of physician care.

Q-What is occurring with the transgender program? A-Two key staff serving transgender populations were lost under Prop. A. One position has been filled, the second was cut from the budget, restored to the budget, then lost again. The Center for Special Problems is looking to hire a physician. They also need a social worker, but have no slot for one. Q-Have all positions been filled? A-No. All the positions are approved, and interviews have been performed. The open position has even been offered to interviewees, but has not been taken.

Announcements

CAEAR Issues: Mike Shriver informed the Planning Council that he will going to Washington, D.C. for a collaborative meeting between the coordinating bodies of Title I and Title II representatives. If Planning Council members have any concerns to be taken to the meeting, please contact him at his office.

Monitorings: Valerie Dorr requested that all Planning Council members please return to her the site visit forms she distributed at the 6/15/92 meeting.

06232gaa

SAN FRANCISCO GENERAL HOSPITAL

OVERVIEW OF HIV RELATED SERVICES

June 22, 1992

1. Introduction — Diane Miller, M.P.H.

2. Inpatient Services — Anne Hughes, C.N.S.
   - Nursing perspective
   - Interaction with Consultation Services
   - Description of Patient Needs

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3. AIDS Division Ambulatory Care Clinics
   - Ward 86 — Jim Kahn, M.D.
   - HIV/IVDU Clinic — Jeff Burack, M.D.

4. Demographics

5. Summary of Issues

SAN FRANCISCO GENERAL HOSPITAL

HIV PROGRAMS

- Inpatient Care

  - In 1991, there were 1,405 HIV related discharges. The average length of stay was 9.9 days. The average daily census was 40 patients.

    20 patients on 5A
    8-10 patients on other med/surg units
    6-12 patients on psychiatric units

  - 6% of all San Francisco hospital patient days are attributed to AIDS; at SFGH 12% of all SFGH patients days are dedicated to AIDS care.

  - SFGH cares for 27% of AIDS patients from San Francisco's hospitals; but 60% of the patients with MediCal. Public Hospitals have been the major provider of medical care throughout the epidemic.

    issue: Medicaid reimbursement does not cover the physician's or hospital's cost.

- Consultations

  - Neurology, Dermatology and GI are the major services providing specialty consultations.

- Ambulatory Care

  - 2,900 patients with HIV disease are cared for by the staff on Ward 86. Another 300 patients are cared for in our primary care clinics. HIV related visits make up 15% of the total clinic volume.

    HIV related services strongly affect key clinical departments:

    25-30% of radiology
    25% of pharmaceutical services
    25-30% clinical laboratory

  - SFGH's AIDS Clinic [Ward 86] has grown by 30% in the last year. With support from Ryan White funding, the Clinic has added services for Early Intervention and on-site medical care at the Methadone clinic.

  - HIV infected patients are also cared for in the General Medical Clinic and Family Health Center. GMC has CARE support for 1.0 nurse practioner for an early intervention clinic.

  - SFGH is working with the DPH Primary Care Network, the San Francisco Community Clinic Consortium and private community providers to improve access to care.

    SFGH provides specialty consultation, diagnostic, emergency and inpatient services for patients cared for in this extended network.

- Health Care Worker Training and Safety

  - SFGH has invested in training and workplace safety. The Occupational Infectious Disease program provides primary prevention and post exposure management for health care workers exposed to needlesticks or splashes.

  - Significant attention has also been applied to our TB polices, early identification, barrier precautions and facility upgrade.

  - SFGH has taken a leadership role in developing policies addressing issues related to occupational exposures, and HIV infected health care workers.

  - issue: Health & Safety issues are becoming increasingly important in the Health Care environment. Concerns about blood borne pathogens and TB are evident in our policies, training programs, budget, labor negotiations as well as in our treatment plans.

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

Overview

1. What is the mission of the AIDS Program?

2. How does Ward 86 function?

3. How are patients cared for on Ward 86?

4. What problems related to patient care have we identified in the AIDS Program?

5. What solutions can we identify for the problems?

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

What is the mission of the AIDS Program?

To provide expert compassionate and sensitive medical and social care to patients with HIV disease. Because HIV infection is a continuous disease process, we must remain involved in the care of patients with asymptomatic as well as with advanced stages of disease. We are committed to care for patients irrespective of acquiring infection, regardless of race, gender, ethnicity or social class.

We are committed to improving patient care as we attempt to improve the quality and the duration of our patients survival.

We have the responsibility to share with other professionals the insight we have gained in caring for patients with HIV disease. We are committed to educate local health care professionals, to improve and expand the care of HIV-patients in our community.

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

How does Ward 86 function?

Initial entry into the system and then they are first seen by the front desk to confirm an appointment.

Next patients are seen in eligibility for screening.

Patients have their vital signs obtained.

Patients are returned to a common waiting room.

A primary care health care provider evaluates the patient.

Patients fare sent to a number of stations: phlebotomy, pharmacy, radiology, nuclear medicine, pulmonary lab, back to eligibility.

Patients return to the front desk for next appointments and appointments for any specialty or referral visits.

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

How are patients cared for on Ward 86?

Medical Care:
- Maintenance and well care
- Acute care for infections, cancers, weight loss
- Triage for desperate care (drop-in)
- Terminal care

Nursing care:
- Intravenous lines, nursing referrals

Nutrition Care:
- Advice, counseling

Pharmacy Care:
- Refills of prescriptions, counseling

Psychological Care:
- Depression, phobias, anxiety, suicide prevention

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

What problems related to patient care have we identified in the AIDS Program?

Lack of adequate space on Ward 86 to provide adequate care for our present patients and NO space for expansion.

Concerns for the lack of flexibility for staff personnel to provide care for our patients.

Concerns regarding occupational risks of our staff and the requirement to attend to the health needs of our staff.

Need to pay attention to overcrowding in the waiting rooms especially as it relates to infection control (tuberculosis).

Need to adhere to all fire regulations. Plans and policies are in place but budgetary concerns remain.

Problems of an overworked and understaffed pharmacy, radiology, laboratory and other critical services.

Mayor's HIV Health Services Planning Council
June 22, 1992
Primary Medical Care AIDS Program SFGH

What solutions can we identify for the problems?

We need more space and support for primary care.

Nurses for:

Care for Intravenous drug users.

Care of the complicated Ward 86 patient often involving chemotherapy, DHPG, anti-retroviral medications, prophylaxis etc.

Care and triage of the tuberculosis patients.

Specialized HIV women's clinic.

Administrative support for:

Eligibility review

Follow-up for patients to attend or reschedule appointments.

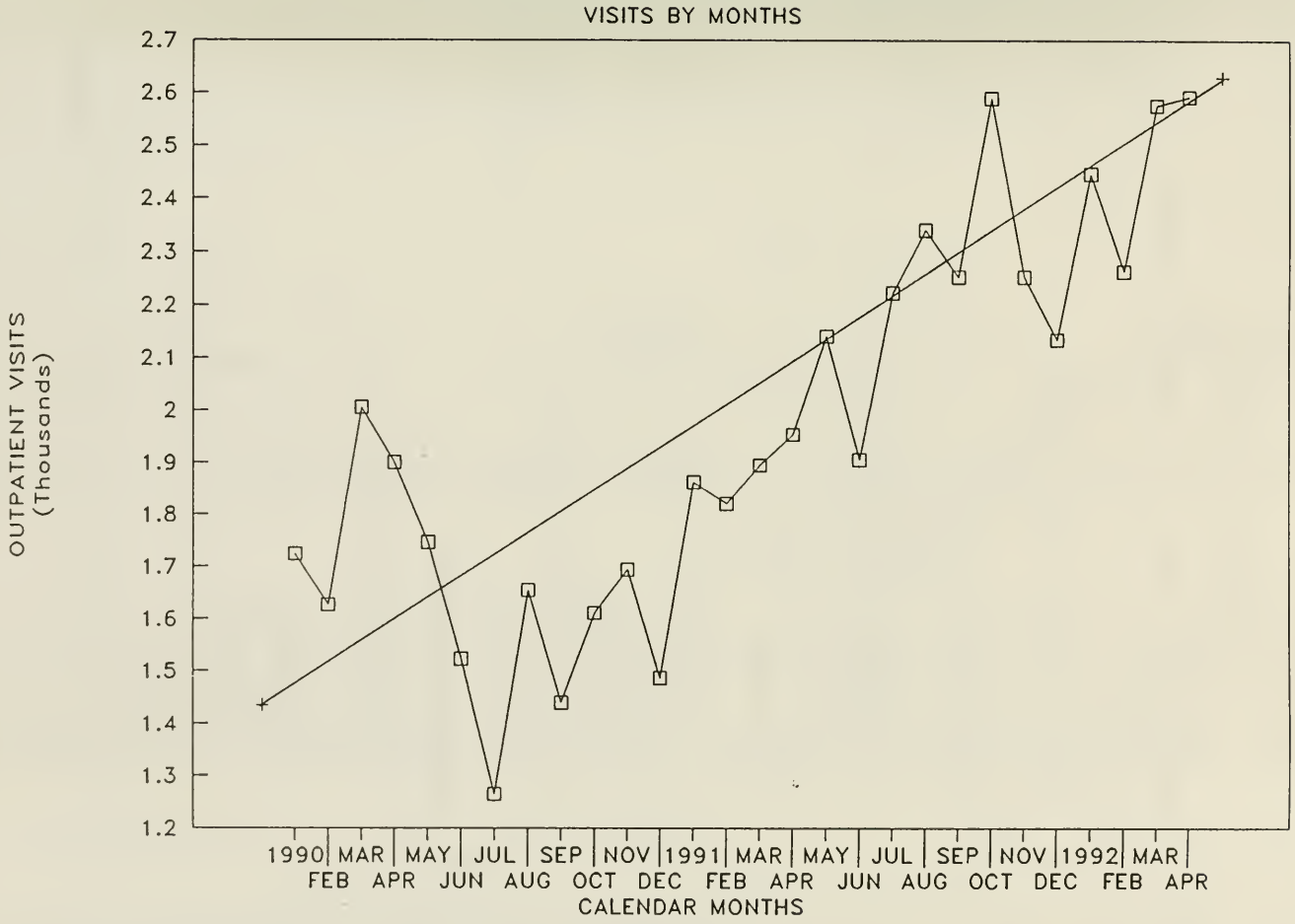
Create linkages for consultations and referrals

Physician support for:

Care of the primary care patients

Triage and care of the acutely ill patients

AIDS OUTPATIENT VISITS



DEMOGRAPHICS

- Inpatient - May, 1992 there were 98 med/surg patients hospitalized:

  - gender: male = 92 female = 6

  - race/ethnicity:

    white = 62 African American = 24
    Latino = 11 Thai = 1

  - risk group:

gay/bisexual male	= 43
IVDU	= 14
gay/IVDU	= 33
heterosexual contact	= 5
unknown	= 3

  - other indicators:

readmitted within 3 weeks	= 15
homeless	= 7
dementia	= 5
hx current drug use [including etoh]	= 40

  - 91 patients covered by MediCal or MediCal pending

SAN FRANCISCO GENERAL HOSPITAL — JULY - DECEMBER 1991

DEMOGRAPHICS OF WARD 86 AND WARD 93 AIDS-RELATED CLINICS: COUNTS BY VISITS

		WARD 86 CLINICS			WARD 93 CLINICS		TOTAL	
SEX		12,317	100.00%		1,509	100.00%	13,826	100.00%
MALE		11,679	94.82%		859	56.93%	12,538	90.68%
FEMALE		638	5.18%		650	43.07%	1,288	9.32%
RACE		12,317	100.00%		1,509	100.00%	13,826	100.00%
WHITE		8,645	70.19%		726	48.11%	9,371	67.78%
BLACK		1,539	12.49%		481	31.88%	2,020	14.61%
NATIVE AMERICAN		7	0.06%		0	0.00%	7	0.05%
HISPANIC		1,526	12.39%		237	15.71%	1,763	12.75%
ASIAN/PAC ISLANDER		268	2.18%		0	0.00%	268	1.94%
OTHERS/UNKNOWN		332	2.70%		65	4.31%	397	2.87%
ZIP CODE		12,317	100.00%		1,509	100.00%	13,826	100.00%
SAN FRANCISCO		11,622	94.36%		1,443	95.63%	13,065	94.50%
TEN MOST COMMON	94114	2081	17.91%	94102	472	32.71%		
ZIP CODES AND	94102	1652	14.21%	94110	202	14.00%		
THEIR PERCENTAGE	94109	1406	12.10%	94103	150	10.40%		
OF TOTAL SAN	94110	1227	10.56%	94109	104	7.21%		
FRANCISCO	94117	1153	9.92%	94117	90	6.24%		
	94103	833	7.17%	94112	59	4.09%		
	94115	615	5.29%	94114	57	3.95%		
	94131	492	4.23%	94115	56	3.88%		
	94107	356	3.06%	94124	54	3.74%		
	94112	261	2.25%	94122	54	3.74%		
OTH COUNTIES		695	5.64%		66	4.37%	761	5.50%
FINANCIAL CLASS		12,317	100.00%		1,509	100.00%	13,826	100.00%
MEDICARE		1,099	8.92%		32	2.12%	1,131	8.18%
MEDI-CAL/PENDING		5,360	43.52%		989	65.54%	6,349	45.92%
MIA		3,383	27.47%		415	27.50%	3,798	27.47%
PATIENT PAY		438	3.56%		73	4.84%	511	3.70%
SLIDING SCALE		248	2.01%		0	0.00%	248	1.79%
RESEARCH		1,277	10.37%		0	0.00%	1,277	9.24%
PRIVATE INSURANCE		489	3.97%		0	0.00%	489	3.54%
OTHERS		23	0.19%		0	0.00%	23	0.17%
AGE		12,317	100.00%		1,509	100.00%	13,826	100.00%
0 - 5		1	0.01%		0	0.00%	1	0.01%
6 - 10		0	0.00%		0	0.00%	0	0.00%
11 - 12		0	0.00%		0	0.00%	0	0.00%
13 - 14		0	0.00%		0	0.00%	0	0.00%
15 - 16		0	0.00%		0	0.00%	0	0.00%
17 - 18		1	0.01%		0	0.00%	1	0.01%
19 - 20		40	0.32%		0	0.00%	40	0.29%
21 - 25		565	4.59%		2	0.13%	567	4.10%
26 - 30		2,235	18.15%		101	6.69%	2,336	16.90%
31 - 35		2,994	24.31%		262	17.36%	3,256	23.55%
36 - 40		2,732	22.18%		462	30.62%	3,194	23.10%
41 - 45		2,149	17.45%		376	24.92%	2,525	18.26%
46 - 50		909	7.38%		138	9.15%	1,047	7.57%
51 - 55		431	3.50%		64	4.24%	495	3.58%
56 - 60		154	1.25%		53	3.51%	207	1.50%
61 - 65		92	0.75%		45	2.98%	137	0.99%
66 - 70		12	0.10%		1	0.07%	13	0.09%
71 - 75		1	0.01%		5	0.33%	6	0.04%
OTHERS		1	0.01%		0	0.00%	1	0.01%

SUMMARY OF ISSUES

- Continuum of Care
  - Hospital-wide standards for HIV Services from prevention & assessment to treatment & care.

    example: Emergency Department project for assessment & intervention of high risk patients.
  - SFGH role in the diagnostic, referral and hospitalization of "network" patients - is SFGH the most appropriate source for these services?
  - Lack of adequate support for infrastructure which affects all services at SFGH
    - Business Plans to increase revenue
    - Long range strategic plans to set system-wide priorities.

- Health Care Financing
  - Reimbursement and Eligibility
  - Determine cost of AIDS care
  - Accurate data systems

- Patient need/demand greater than the System can support

CITY CLINIC HIV CARE PROGRAM

Program Start Date: 1/29/92 June 12, 1992

I. Patient Demographics

A. Gender

Male	74 (99%)
Female	1 (1%)
Transgender	0 (0%)

B. Patient Group

Gay/Bisexual Male	60 (80%)
Gay/Bi Male & IDU	9 (12%)
Heterosexual IDU	3 (4%)
Heterosexual	3 (4%)

C. Ethnicity

White	43 (57%)
African-American	21 (28%)
Latin/Hispanic	7 (9%)
Asian/Pac Islander	2 (3%)
Native American	2 (3%)

D. Age

20-29*	29 (39%)	*20-24	13 (17%)
30-39	31 (41%)		
40-49	12 (16%)		
50-59	2 (3%)		
60-69	2 (3%)		

E. CD4 Count

Under 200	10 (18%)
200-500	38 (68%)
Over 500	8 (14%)

II. Service Contacts

A. Service Summary

Patient Intakes	75 (8 intakes pending)
Active Patients	58 (12 discharged / 5 left program)

Total Service Contacts	492
Psychosocial Services	268 contacts
Medical Services	224 contacts

B. Psychosocial Services

Psychosocial Assessments	75/83 scheduled completed (90%)
Service Planning	66 contacts
Case Management	127 contacts

C. Medical Services

Medical Evaluations	66/69 scheduled completed (96%)
Medical Follow-Up	104 appointments
Medical Drop-In	54 contacts

Paul M. Gibson
HIV Care Coordinator

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: City Clinic / Paul M. Gibson, LCSW

Service Site: 356 7th Street / 1372 Mission Street

Target Population: Underserved/uninsured STD patients with HIV who have not accessed health care and have no other current provider.

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Client Demographics: (Number Served/Percentage of Total)

Male 74 (99%) Female 1 (1%)

White 43 (57%) African American 21 (28%) Latino 7 (9%)

Native American 2 (3%) Asian/Pacific Islander 2 (3%)

Service Description:

City Clinic provides integrated HIV medical and psychosocial services for STD patients. 2,000 persons with HIV obtained STD services from us in 1991 with 276 HIV positive persons found in our testing program. The Clinic began providing HIV care on January 29, 1992 with 75 patients seen as of June 12. Patients are referred directly from HIV post test counseling and from STD examinations.

HIV CARE positions include a 1.0 Senior Social Worker (HIV Care Coordinator), 0.4 Physician Specialist (HIV Attending Physician) and 1.0 Medical Social Worker. HIV Medical services are provided on Thursday mornings at the Clinic by appointment and are supervised by the Medical Director. HIV psychosocial services are provided weekdays by appointment at the Clinic Annex. HIV Team Meetings are held biweekly with all HIV staff to discuss program issues and services.

Patients are initially seen for an intake and psychosocial assessment. This interview explores the patient's history and current needs regarding social, psychological and environmental factors impacting their health. The patient is then scheduled at the HIV Clinic for a complete medical evaluation including a medical history, physical exam, blood tests, a PPD and the pneumovax. They return in two weeks for their lab test results and treatment planning.

After initial staging, patients receive medical follow-up and case management services at 3 month intervals or as needed. Patients with an AIDS diagnosis, a CD4 count under 200 or an unstable medical condition are referred to a long term primary care provider. HIV Case Conferences are held biweekly to review patient service plans and discuss referrals and discharge planning as appropriate.

Our HIV patients have extensive medical and psychosocial needs and are not well connected with other service providers. 86% have CD4 counts under 500 requiring frequent medical follow-up and AZT monitoring. Many have basic survival needs, alcohol/drug use problems and psychiatric histories that require intensive case management. The City Clinic HIV Care Program works with the HIV service network to access underserved patients to HIV care, expand their community service resources, monitor patients with stable medical conditions and identify person with advance HIV disease for referral to long term primary care.

Funding Sources: CPHS Primary Care/Supplemental Care Grants

City and County of San Francisco

Department of Public Health

TOM WADDELL CLINIC

AIDS Service Status Report
FY 1990-91

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1. Description of AIDS Services and Services to HIV-infected Clients

The Clinic provides a multidisciplinary approach to all client care, using the services of medical providers, mental health workers, social workers and outreach workers. This multidisciplinary team provided over 40,000 contacts in FY 90-91 to a population base that is approximately 80% homeless and 90% multiply diagnosed with mental illness and/or substance abuse. The Clinic providers estimate that 90% of our client base is at risk for HIV, and prevention services are offered to 100% of our client population.

The HIV multidisciplinary team provides primary care on-site and care at outreach sites such as the Ambassador Hotel and Maitri Hospice. This team provided medical services to just over 1,000 individuals requiring 3,429 visits during FY 90-91.

The rest of the Clinic's HIV primary services are spread throughout the Primary Care Clinic programs and comprise approximately 1,100 additional HIV+ individuals. (A study conducted by Andrew Moss et al, FY 90-91, indicated that 11% of the Clinic's client base was HIV+.)

The HIV Primary Care Clinics function 12 hours a week, and see between 10-15 new patients per week. The waiting time for a new patient appointment remained at an average of 5 weeks both at the beginning and the end of the fiscal year.

The Clinic collaborates with VNH and A.I.D.S. at the Ambassador Hotel to provide multidisciplinary services. We provide a continuity of care at Maitre Hospice, Ward 86 and Ward 92. Consultative and referral efforts exist between City Clinic and the T.B. Clinic, and we directly admit to San Francisco General Hospital via Family Practice.

As in all programs, staff is funded by the Health Care for the Homeless Program and Tom Waddell Clinic.

50 Ivy Street, San Francisco, CA 94102
(415) 554 - 2960

HIV Health Services Planning Council

Agency:	Health Center #1, Department of Public Health
Service Site:	3850 17th Street
Target Population:	Residents of the Castro, Potrero Hill, Mission Districts of the City Zip Codes 94114, 94110, 94117, 94131, 94103, 94107
Client Demographics	July, 1990 through June, 1991 635 males (92%) 32 females (8%) Ethnicity: White 74%, African American 4%, Latino 14%, Native American .2%,Asian/Pacific Islander 2.5%

SERVICE DESCRIPTION: Health Center #1 provides comprehensive HIV primary care medical, social service and mental health services to patients with HIV infection. The clinic provides services to patients with all stages of the virus, asymptomatic through seriously ill. Each month 7-10 of our patients die of the disease. About 65% of the HIV-related physician visits at the health center are of patients with T4 cell count under 200.

There are 6 half-day HIV primary care clinics scheduled each week. HIV patients are also seen in four General Primary Care Clinics and, in July 1992, Health Center #1 will expand HIV Clinic services to Monday evenings. The Clinical staff works very closely with on-site Alternative Test Site (ATS), public health nursing and mental health staff. A Health Center #1 physician is on-call 24 hours, 7 days a week. Clinic staff also coordinate and link patients with other support services such as substance abuse counseling/treatment and benefits counseling available at the Center for Positive Care, the AIDS Health Project and other City and community-based organizations. About 10 % of our patients are currently enrolled in special HIV clinical trials.

In FY 1990-91, Health Center #1 provided care to 667 patients with HIV. There were 3,759 HIV patient visits with an average of 5.6 physician visits per patient. In 1991-92 the number of patients seen is projected to have risen to about 725 patients. As a result of receiving Care funding in 91-92, Health Center #1 physicians have seen 176 new patients with HIV since April 1991; previous to receiving this funding, the clinics were at capacity. HIV-related patient visits currently constitute over 40% of all physician visits at Health Center #1 physician.

Other HIV related Health Center activites include:

-two AIDS Health Project teen peer educators are on site during Health Center #1 Teen Clinic to provide drop-in education/counseling services to teens.

-Two teen counselors are assigned to a HC#1 health educator through the Mayor's Youth Summer Employment Program to develop a training for youth peer counselors and outreach workers in the Health Center #1 district.

-A health educator provides parent peer education training through the Catholic Archdiocese.

-A health educator in conjunction with grass roots "community" developed a teen/family educational video "Between Friends" which received a national award for excellence and has been incoroporated into California middle schools curriculum.

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-public health nurses provide home visits to about 20 temporarily homebound patients with HIV monthly
-Health Center #1 Staff are working in conjunction withthe Mission Real Alternatives Program (RAP) to open a community-based teen clinic which will provide HIV prevention/education. The clinic will open in September 1992.

FUNDING SOURCES: Of an approximate $1.7 million Clinic budget, the health center receives the following HIV service-specific funding. General Fund (HIV Health Centers) $155,000; 1991-92 Ryan-White Care funds $115,000. An additional allocation by the Care council of about $107,000 for 1992-93 (one time only funding) will provide staff for HIV evening clinic services during 1992-93. Community Mental Health Services (located at Health Center #1) funding is not included.

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: Care Team Special Programs for Youth

Service Site: Larkin Street Youth Center - Cole Street Medical Clinic, Youth Guidance Center

Target Population: Adolescents Age 12-23 yrs

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Client Demographics: (Number Served/Percentage of Total)

Male 29(91%) Female 3(9%)

White 21(66%) African American 5(16%) Latino 4(13%)

Native American 0 Asian/Pacific Islander 2(6%)

Service Description:
The Special Programs for Youth (SPY) CARE team currently provides medical care for HIV+ adolescents at three different sites: Larkin Street Youth Center, Cole Street Youth Center, and the Youth Guidance Center.

The team is designed to provide comprehensive primary medical care to HIV+ youth until the age of 23.

Services include primary care and early intervention provided by a nurse practioner at the sites with consultation and referral to SFGH and UCSF when appropriate. Access to Clinical Trials; currently our patients are eligible for only one clinical trial. Perscriptions are filled through SFGH's pharmacy. Patients are referred for psychological support services to CARE case management team. Laboratory drawn on site and taken to either SFGH or DPH central lab. Dental care referred to University of the Pacific. Medical care does not include Alternative therapies or Nutritional Services. No Institutional or Home Health Care Programs. Importantly, we do not have access to Hepatitis B Vaccine.

As of March 31, 1992, we have served 32 clients. The demographics are: Ages 12 to 19---12, 19 to 23---20. Transmission Risk: Gay/Bi-Sexual--11, Gay/Bi-Sexual and Injection Drug User--15, Injection Drug User Only--1, Partner in High-Risk Group--3, Other--2. Housing Situation: With Family/Friends--21, Alone--8, Unknown--3. Payment Source: None--22, Medi-Cal--4,Private Insurance--4, Other (VA, Champus)--2. Clinic Utilization: Patients are scheduled for regular health care maintenance every 3 months. Approximately 1/2 comply with the schedule. Approximately 1/2 of patients come into the clinic about every 2 to 4 weeks for acute visits. Client Profiles - Medical Diagnosis: HIV+---25 (78%), ARC/Disabling HIV---7(22%). HIV Related symptoms are: Thrush, diarrhea, abcesses, one patient with peripheral neuropathy, one patient with herpes opthalmia and one patient with +PPD. One patient on AZT, although approximately 40% are eligible. 40% non compliant because of side effects of AZT and AZT interferes with drug use.

Funding Sources:
Department of Public Health
CARE
National Institute of Allergy and Infectious Disease
Maternal and Child Health Bureau
Department of Health and Human Services

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HIV HEALTH SERVICES PLANNING COUNCIL
SERVICE ARE PROVIDERS

Agency/Individual: DEPARTMENT OF PUBLIC HEALTH CPHS

Service Site: SOUTHEAST HEALTH CENTER

Target Population: BAYVIEW HUNTERS POINT AREA

Client Demographics: (Number Served/Percentaage of Total)

Male-45 Female-55

White - 6 African American - 80 Latino - 6
Native American - 2 Asian/Pacific Islander - 6

Service Description: **Primary Care Site Offering:**

Pediatric Care
Comprehensive Perinatal Care
Family Planning/Womens Health Care
General Adult Medicine
Geriatric Care
Podiatric Services
Nutritional Counseling
Adult and Pediatric Dental Care
HIV Testing and Counseling
(Confidential)
STD Services
Acute Care Drop In Services

(Clinic Hours 8:30-5:00)

Medical Specialty Testing Referral Sites:

San Francisco General Hospital
U.C. San Francisco
Saint Lukes
Various Community Centers

Funding Sources: Department of Public Health
State Office of Family Planning
Center of Disease Control

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: PUBLIC HEALTH LABORATORY/DR. ARTHUR BACK

Service Site: DPH CENTRAL OFFICE, 101 GROVE ST.

Target Population: CLIENTS OF DPH PRIMARY MEDICAL CARE PROGRAMS-

TB Chest Clinic, City Clinic, District Health Centers # 1-#5, Tom Wadell,
Youth Guidance, Southeast, Potrero Hill,

Client Demographics: (Number Served/Percentage of Total) Demographics Reflect that of the clinics served.

Male _____ Female _____

White _____ African American _____ Latino _____

Native American _____ Asian/Pacific Islander _____

Service Description:

Currently provided communicable disease diagnostic testing services in support of DPH primary medical care programs.

- Tuberculosis testing- 4,000 patients per year.
- Syphilis serology testing- 42,000 patients per year.
- Gonorrhea testing- 50,000 patients per year.
- Virus serological testing- 3,000 patients per year.
- HIV antibody testing- 40,000 patients per year.
- Toxicology testing- 5,000 patients per year.
- Chlamydia testing- 20,000 patients per year.

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In-development services.

- Rapid diagnostic and drug susceptibility testing of tuberculosis.

Limits to service.

- Rapid diagnostic and drug susceptibility testing of tuberculosis is limited to the existing volume of patient specimens per year (approx. 4,000) due to lack of personnel time to handle the demand for more patients to be served.

Funding Sources:

Ad valorum funding for all services except for HIV antibody testing (State and Federal funding).

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Caleb G. Clark
Potrero Hill Health Center

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: DPH,CPHS-Michael Drennan,MD, Center/Medical Director.

Service Site: Potrero Hill Health Center (PHHC)

Target Population: Potrero Hill and surrounding communities (Mission Bernal Hill, South of Market Northern Bayview), any individuals seeking comprehensive primary care services.

Client Demographics: (Number Served/Percentage of Total)

Male 31(82%) Female 7(18%)

White 19(50%) African American 14(37%) Latino 5(13%)

Native American 0 Asian/Pacific Islander 0

Funding Sources: DPH/ General fund for all operating budget, except:
1: AIDS funding for 0.8 FTE MD position and 0.5 FTE MSW.
2: S.F. School of Podiatry for 0.1 FTE DPM

1050 Wisconsin Street · San Francisco, California 94107 · (415) 648-3022

POTRERO HILL HEALTH CENTER - SERVICE DESCRIPTION

Caseload Overview:	Primary medical and dental care since 1976, first known HIV(+) diagnoses in 1985, first AIDS death of PHHC patient in 4/87. On-site confidential HIV antibody testing since 1986. Total known HIV (+) patients to date = 65. Current HIV (+) caseload = 38 patients (CD4 <200=8, 200-500=24,>500=6); recent increase in women, African-Am., and Latino percentage. IDU'S = 13% of total. Most followed throughout disease progression.
Clinic Staffing:	3 MDs (2.4 FTE), includes 2 FPs,1 internist/infectious diseases; 0.5 FNP (only female provider); 2 Dentists, 2 Dental Assts; 2.5 RNs ,Orderly, Lab Tech, 3 Clerks.
Clinic Types and Scope of Services:	All medical clinic sessions are "primary care" with a mix of patient types, i.e. not dedicated clinics organized by diagnosis (HIV,etc), age,etc. All patients oriented to center's emphasis on continuity care, including acute and chronic illness care, preventive health maintenance, patient education and community outreach. First patient visit includes comprehensive medical evaluation, inc. H&P, lab, knowledge assessment, and referral to MSW. On-going care includes regular check-ups, labs, prescriptions & referrals as indicated. Referrals are usually to SFGH specialty clinics. Admissions usually to SFGH.
Linkages:	SFGH; CPAT; local schools (classroom presentations,etc.) Potrero Hill Neighborhood House (outreach to youth) Potrero View newspaper (HIV related articles).
Special Features:	Spanish, Tagalog; Home + Hospital visits by MD/FNP staff.
Future Plans:	Increase HIV(+) patients seen by improved outreach centralized referral system.

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Department of Public Health
District Health Center #2
HIV/AIDS Services (6/92)

District Health Center #2 1301 Pierce Street at Ellis
Melissa Welch, MD Medical Director

Target Population: Residents of the Western Addition, Hayes Valley, Inner Richmond, the Tenderloin, Haight, Marina, and Pacific Heights.

Demographics: **NON-HIV patients** - 65% Women 35% Men
65% Black 20% White 10% Latino 5% Asian/PI
HIV patients - 2% Women 98% Men
2% Black 96% White 2% Latino 0% Asian/PI
HIV Transmission - 94% Gay/Bisexual 5% IDU 1% Other

Service Description:

Services for HIV/AIDS patients at Health Center #2 include comprehensive primary care, HIV testing and counseling (Anonymous and Confidential), and HIV/AIDS case management and psycho-social assessment.

1. Primary Care Clinics M-F 8:30AM-5PM
-Primary Care encounters per month: average 300
-Total HIV encounters per month: average 12 (New ~1-3 Return ~11)
-HIV encounters 1/92 through 5/92: 57 (7 New)
-estimated Total number of HIV patients: 75 - 100 (to date)
-Staffing: 1.7 FTE MD's (0.5 CARE) 2 FTE RN (0.5 CARE pending) 0.5 FTE MSW (CARE)

All patients are cared for in primary care clinics. Patients receive care for their HIV and non-HIV related conditions. Initial evaluation include a comprehensive medical exam, ordering/prescribing all needed labs and prescriptions and a referral for a psyho social assessment (on site). Patients are assigned to a provider who sees the patient for all of his/her return visits. If a patient is hospitalized we try to visit them in the hospital to facilitate continuity of care and to ensure follow-up with us after the patient's discharge.

HIV Testing and Counseling

We do confidential AIDS testing and counseling in our primary care and family planning clinics. All of our physicians and one of our nurses (as well as a pat-time nurse) are trained to provide HIV testing and counseling.

2. Medical Social Services (since 1/92)

Our Medical Social Worker does an initial, general evaluation on all HIV/AIDS patients. This evaluation assesses social (food, financial, living etc) and psycho-social needs (such as mental health needs). When patients referred to our center have urgent or concerning psycho-social needs, they may be seen initially by our social worker, and then receive a follow-up appointment by one of our clinic physicians.

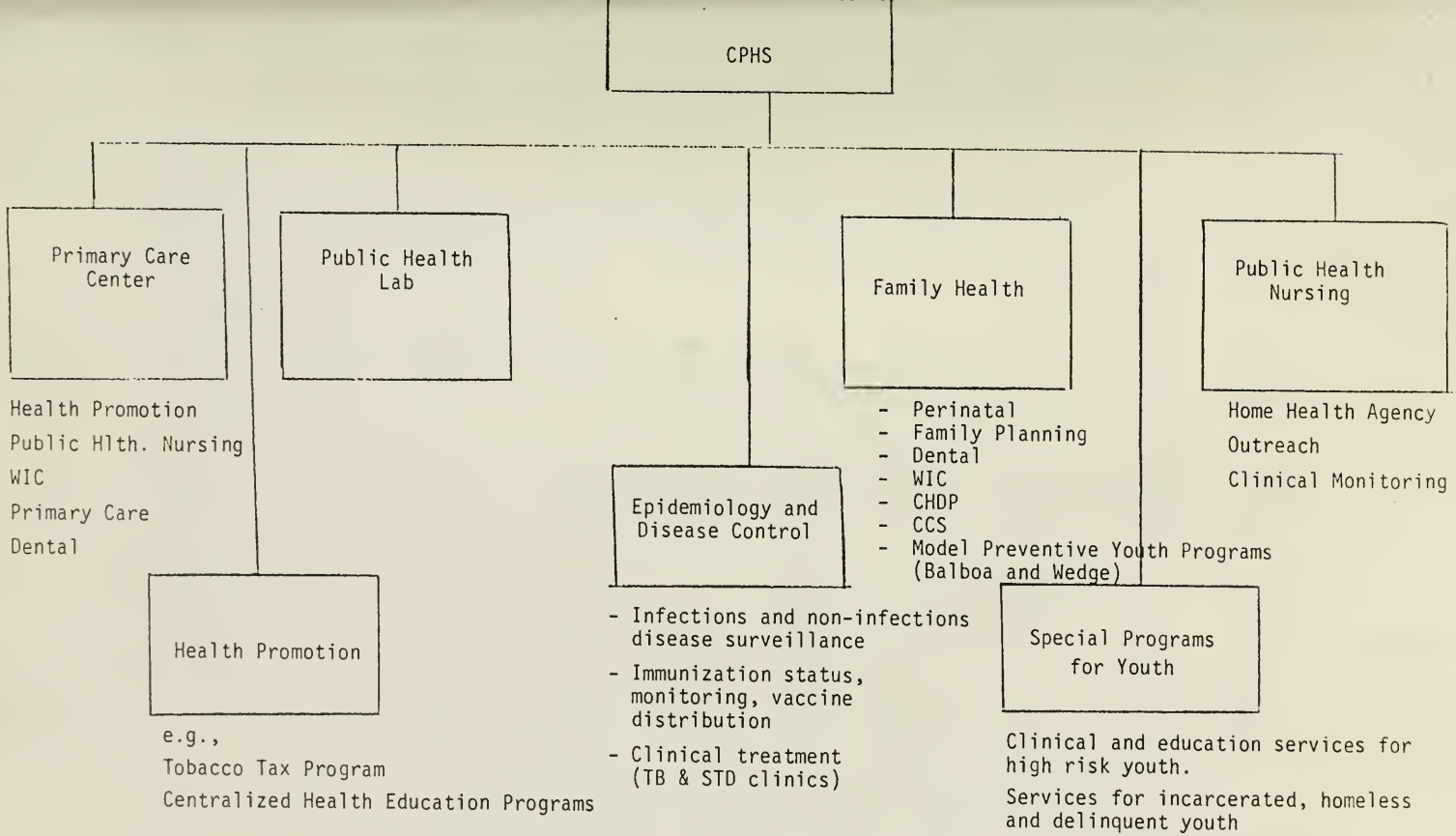
Community Collaborations

-Westside Methadone Maintenance (housed at Health Center #2) - we co-manage HIV/AIDS patients on methadone maintenance
-AIDS Health Project ATS- HC#2 is an anonymous testing site; we receive referrals from ATS and refer to it
-SF General Hospital - a source of referrals; our main admitting hospital.

New Priorities/Programs:

Public Relations: District Health Center #2 AIDS services were discussed on the VIACOM Cable, channel six program 'Helping Hands'. We hope to generally increase our numbers of HIV patients, particularly ethnic minorites.

Access to AIDS Continuity Care Clinic (ATACC Program) - beginning July 21, 1992 through January 26, 1992 This clinic aims to increase the number of HIV patients cared for at Health Center #2 and to insure better access to primary continuity care for HIV infected patients. Patients will receive an appointment within 3 weeks for a comprehensive evaluation and be assigned to a continuity care physician.



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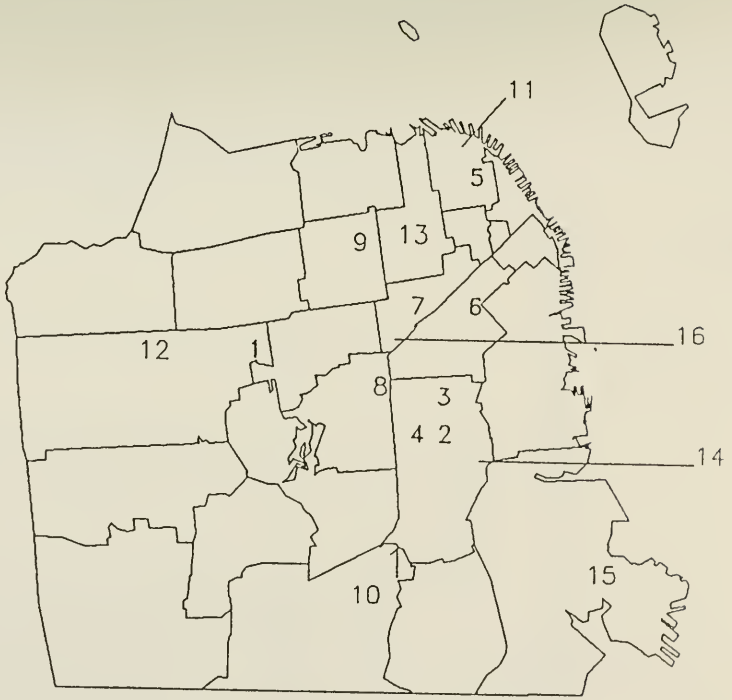
CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
PRIMARY CARE NETWORK

PERCENT 1991 PATIENTS, BY SITE,
BY AGE, SEX, ETHNICITY AND
INSURANCE STATUS

	TOTAL	DHC 1	DHC 2	DHC 3	DHC 4	DHC 5	SOUTH EAST	POTRERO HILL
TOTAL	35,778	8,434	1,428	5,226	7,670	5,978	4,222	2,820
AGE:								
< 1	2.2%	1%	N/A	2%	5%	1%	2%	2%
1 - 14	27.8	27	N/A	37	34	24	17	21
15 - 19	8	10	N/A	11	7	8	7	6
21 - 24	7	7	N/A	11	4	9	9	6
25 - 59	46	52	N/A	34	46	41	50	49
60+	9	3	N/A	5	4	17	15	16
Total	100%	100%		100%	100%	100%	100%	100%
SEX:								
Male	38%	49%	44%	32%	30%	38%	41%	41%
Female	62	51	56	68	70	62	59	59
Total	100%	100%	100%	100%	100%	100%	100%	100%
ETHNICITY:								
Asian/Pacific Islander	33%	5%	14%	21%	93%	42%	4%	7%
Black	20	4	20	29	.1	5	83	49
Hispanic	22	52	6	38	.1	6	5	20
Non-Hispanic White	19	28	58	7	5.8	40	4	6
Other/Unknown	6	11	2	5	1	7	4	18
Total	100%	100%	100%	100%	100%	100%	100%	100%
INSURANCE STATUS:								
Medically Indigent	8%	15%	N/A	--	21%	11%	--	--
Medi-Cal	36	25	N/A	48%	32	6	62%	58%
Medicare	8	5	N/A	2	1	--	26	17
Private Ins.	2	2	N/A	2	1	3	4	2
Self-Pay/Other	46	53	N/A	48	45	80	8	23
Total	100%	100%		100%	100%	100%	100%	100%

ommunity Based Clinics for Low Income Children, an Francisco, 1990

1	Haight Ashbury Free Clinic
2	Lyon–Martin Women's Health Svcs
3	Mission Neighborhood Health Ctr.
4	Native American Health Ctr.
5	North East Medical Services
6	South of Market Health Ctr.
7	Saint Anthony's Clinic
8	Health Ctr. #1
9	Health Ctr. #2
0	Health Ctr. #3
1	Health Ctr. #4
2	Health Ctr. #5
3	Larkin Street Youth Ctr.
4	Potrero Hill Health Ctr.
5	Southeast Health Ctr.
6	Tom Waddell Clinic



Source: San Francisco Community Clinic Consortium
DPH Family Health Bureau

: Clinics 1 thru 7 are affiliated with the San Francisco Community Clinic Consortium. Clinics 8 thru 16 are part of the DPH Primary Care Network. Clinics # 3–5, 8–12 & 14 are Community Based Perinatal Poviders and CPS Providers.

HIV HEALTH SERVICES PLANNING COUNCIL

June 29, 1992

The Agenda of this meeting is missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

June 29, 1992
4:30 - 7:00 p.m.

Minutes

Members Present: Reggie Williams, Marcy Fraser, Yvonne Frazier, Jaime Geaga, Les Hanson, Kent Macdonald, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Sylvia Villareal, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Michael Baxter, Pat Christen, Maria Church, Moher Downing, Estela Garcia, Karen Hembry, Gerald Lenoir, Gifford Leoung, Steve Lew, Pierre Ludington, Scott Miller, J.B. Molaghan, Darol Nance, Bob Nelson, Patricia Underwood

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Joe Jung, Jon Dean Green

I. Roll Call

Roll Call was taken as above. A quorum was not present.

II. Review and Approval of Minutes

Approval of the June 15, 1992 minutes was postponed until the July 6, 1992, meeting due to the lack of a quorum.

III. Title VIII HOPA Parameters

Discussion was postponed until the July 6, 1992, meeting due to the lack of a quorum.

IV. Preparation for Y02 Monitorings

Yvonne Frazier briefly discussed the Subcommittee on Evaluation's efforts to rework the Monitoring Protocol to make it more quantifiable and an objective tool. Ms. Frazier asked the Planning Council to set the date for the upcoming public hearing to take testimony from consumers of services. The consensus of the Planning Council was to set the date for Wednesday, August 5, 1992, between 4:00 - 6:30 p.m. Planning Council members unable to attend this meeting should notify Jon Dean Green at 554-9060. Sophia Chang reminded the Planning Council that the purpose of this meeting was to hear public testimony on service gaps and/or service problems from consumers of service, not providers.

V. Titles I & II Y01 Rollover Funds

Discussion was postponed until the July 6, 1992, meeting due to the lack of a quorum.

VI. Review of Citywide Primary Medical Care Programs

Ralle Greenberg, Forensic Services

(Please refer to enclosed handout.)

Ms. Greenberg explained that the nurse has been in place in the program since November, the social worker for three months. She went on to say that for many of the people Forensics sees, this is the client's point of entry into the medical system and the clients have never received prior HIV-related medical care.

Q-How many people have been paroled through the compassionate release program? A-Five. Ms. Greenberg stated the program's philosophy is, "No one should die in custody."

Jessica Clark, St. Mary's Hospital
a) Outpatient Medical Care b) Dementia Unit

(Please refer to enclosed handouts.)

Dementia Unit:

Q-Is this a hospice style program? A-The focus is not to provide hospice services, though 44% of patients have died in the unit. Rehabilitation is the focus of the unit.

Q-How are patients referred to St. Mary's? A-St. Mary's takes clients after an initial dementia diagnosis and work up is performed. St. Mary's has the capacity to take more referrals.

Q-Does the unit work with substance abuse/dementia patients? A-Yes. Substance usage does not preclude patients from being placed on the unit.

Q-Does the unit take women? A-Yes.

Outpatient Medical Care:

Q-Are most clients symptomatic or asymptomatic? A-Asymptomatic.

Q-Are there exclusion criteria for active substance users? A-No.

Q-What is the catchment area for the program? A-The Tenderloin, Haight, Golden Gate areas of the City.

Q-Is there a waiting list? A-Not at present, though there probably will be one soon. The cap is 180, and there are currently 177 patients. Dr. Clark is asking St. Mary's administration to allow the program to take more patients.

Q-What is the waiting time for an appointment? A-Same day to three days.

Nydia Rosales, Latino AIDS Services, Mano-a-Mano

(Please refer to enclosed handouts.)

Q-What is the current staffing? A-Two case managers and one therapist.

Q-How many clients attend group therapy? A-Six of the clients undergoing individual therapy, and the group is open to any of the clients at the agency.

Q-How large is the group? A-Average group size is 4-6, the largest was twelve. The groups are drop-in and conducted in Spanish.

Q-How many clients are currently seen? A-Thirteen are in individual therapy.

Gene Gowdy, University of the Pacific Dental School

(Please refer to enclosed handout.)

UOP's program has been an overwhelming success. UOP contracted to serve 750 clients and to provide 3000 UOS. It has seen 850 clients and provided 4000 UOS to date. Dr. Gowdy stated UOP's commitment to serving indigent clients is demonstrated by UOP not having restricted access to care, even though it has fulfilled its contract objectives. Dental care is provided by students under the guidance and supervision of the faculty. Every client entering the program is examined by Dr. Gowdy. The goal of the program has been, "Advice with encouragement and care with dignity."

Q-How many of the clients have medical insurance as opposed to no dental insurance? A-Most patients have no payment source for dental needs. Perhaps 30% qualify for Medi-Cal and <1% have private insurance.

Q-Who else is serving dentally indigent clients? A-Other than some services at UC, no one.

Q-Is there patient dumping going on? A-Yes.

Q-What is the eligibility criteria for service? A-There is no eligibility criteria. It is obvious that the the vast majority of clients are indigent and in severe need of services. Very few are finessing the system and able to pay.

Q-Are clients presenting late? A-Yes. Many clients present late expecting to be treated poorly and are surprised at the decent treatment they receive at UOP.

Dr. Harvey Brody, UCSF School of Dentistry

(Please refer to enclosed handout.)

Dr. Brody began by explaining that the monies received by the UCSF Dental School come from Ryan White Care Title II funds-Programs of National Significance. The funding mechanism is such that UCSF provides care for persons with HIV as part of their regular services for a year. UCSF then retrospectively demonstrates unreimbursed care, and applies competitively with other dental schools for dental monies set aside in Title II-Programs of National Significance.

During 1989-90, UC saw 2599 HIV infected patients. The average number of visits per patient was 5.52

Gail McBride, Family Service Agency

(Please refer to enclosed handouts.)

Ms. Mcbride explained that the HIV program is part of the overall Medically Indigent Adult program ran by Family Service Agency. Two major barriers to access to service that Family Service Agency addressed concerning eligibility were: a) the program allows a higher income level for eligibility, and b) the program also covers persons who were underinsured, as opposed to only those persons who are uninsured.

The majority of the contract is from monies received from the Department of Mental Health. Currently those funds are in jeopardy due to the State budget crisis. Family Service Agency will try and maintain the contract even in the DMSF monies are lost.

Q-Would Family Service Agency be able to perform the neuropsychiatric workups needed for persons to enter the St. Mary's dementia unit? A-If the clients met the eligibility requirements, yes.

Jim Illig, Continuum

(Please refer to enclosed handout.)

Mr. Illig stated that a concern of Continuum's was its inability to receive on-site physician care from either Ward 86 or the Health Centers.

Q-How many hours of physician time would Continuum need? A-Six hours per week.

Dennis Yamamoto, San Francisco Community Clinic Consortium

(Please refer to enclosed handouts.)

Q-How are the funds allocated to the different clinics? A-In the first year it was by formula. In the second year allocation has been based more on usage.

Announcements:

Mike Shriver announced that the markup for CARE monies was to be done on Wednesday, July 1, 1992. He asked that all Planning Council members call the California delegation-Senate, and Representatives for Northern districts-and inform the Members of the need for further CARE, research and prevention funding. Mr. Shriver also emphasized that the Members need to call Representative Natcher, (D) Kentucky, Chair of the Subcommittee on Appropriations, and ask that Rep. Natcher push for higher funding of CARE, prevention and research.

City and County of San Francisco

Department of Public Health

JAIL MEDICAL SERVICES
Forensic Aids Project
Social Work Unit
798 Brannan Street
San Francisco, California 94103
(415) 863-8237
(415) 863-8243

Presentation - June 29, 1992

HIV Health Services Planning Council
Service Area Providers
HIV Primary Medical Care Services Continuum

Agency/Individual: Ralle R. Greenberg Ed.D LCSW, San Francisco Department of Public Health, Forensic Services, Forensic AIDS Project.

Service Site: All of the San Francisco County Jails

Target Population: Men and women incarcerated at least one month in the San Francisco County Jails.

Client Demographics: (From: November 15, 1991 - June 15, 1992)

Male: 249 Female: 21 Transgender: 1

White : 125 African American: 89 Latino: 45

Native American: 4 Asian/Pacific Islander: Other 8 (others includes those who choose to define themselves this way).

Service Description:

The Forensic AIDS Project is a program administered by the Department of Public Health's Division of Forensic Services. It is designed to provide HIV, AIDS, and STD education, information, counseling and referrals to all inmates who are housed in the three San Francisco County Jails, and the Security Ward (7D) at San Francisco General Hospital.

In conjunction with the San Francisco court system, HIV education and testing are provided for men and women referred because of certain criminal offenses. In addition, FAP provides training for criminal justice workers and community workers working with people in the criminal justice system.

The San Francisco County Jails houses a large number of people whose behaviors, in spite of extensive AIDS education puts them at risk for HIV infection. For most inmates, incarceration is the time when they take care of their medical needs making HIV Early Intervention Services essential.

A team consisting of a Registered Nurse and a Medical Social Worker, in conjunction with certified HIV Educators who do outreach in the four San Francisco County Jails, encourage inmates to participate in the HIV Early Intervention Services. Inmates will self select or be referred by Educators, Jail Medical Services, and/of Jail Psychiatric Services personnel for medical intervention, case management and informational and community referrals.

The program is threefold.

To provide full medical evaluation of all those HIV positive inmates who are incarcerated for one month. This includes: evaluation of past medical history, detailed history of current status, TB testing and provision of treatment in jail including immunizations, laboratory tests physical exam, and medications.. Active medical referrals upon return to the community, which includes the arrangement of a medical summary and medical appointments upon release.

To provide social case management to all inmates who are identified as HIV positive who will be in custody for one month. This includes: Psycho-social evaluation, counseling and education while in jail, and referrals to community resources upon release. The social worker actively works with community agencies so that they will accept ex-offenders. In addition, as a result of extensive networking, community workers call when their clients are incarcerated, facilitating the continuity of care.

To obtain compassionate release for eligible inmates who are terminally ill. This includes placement in a community residence or hospice setting, practical/emotional support and networking with hospitals and nursing services.

Funding Sources:

Combined funding: Ryan White Care monies provide salaries for RN and MSW.

Department of Public Health, Forensic Services funds materials and equipment.

HIV HEALTH SERVICES PLANNING COUNCIL
SERVICE AREA PROVIDERS

Agency/Individual: ST. MARY'S HOSPITAL AND MEDICAL CENTER

Service Site: SR. MARY PHILIPPA MEMORIAL CLINIC
PRIMARY MEDICAL CARE SERVICES, ROUTINE MEDICAL CARE, INCLUDING PEDIATRIC & MEDICAL EARLY INTERVENTION, PHARMACY, GYNECOLOGICAL SERVICES, SPECIALTY CARE (BY REFERRAL) LABORATORY, MENTAL HEALTH/PSYCHIATRIC (PSYCHOLOGICAL/NEUROLOGICAL EVALUATIONS)

Target Population:* PERSONS WITH HIV DISEASE WHO HAVE NO OTHER SOURCE OF HEALTHCARE AND INSURANCE.

Client Demographics: (Number Served/Percentage of Total)

Male: 172/97% Female: 5/3%

White: 122/69% African American: 29/16% Latino: 17/10%

Native American: 3/2% Asian/Pacific Islander: 6/3%

Service Description:

Comprehensive outpatient healthcare services for HIV seropositive individuals are designed for those who are without healthcare benefits and do not have a heathcare provider.

Primary and support services are rendered in the general medicine and the HIV subspecialty clinics of the Sr. Mary Philippa Memorial Clinic (SMPM Clinic). Patients are assigned to a multidisciplinary team composed of a primary care physician or nurse practitioner, the staff nurse and a case manager. Primary healthcare is provided by house officer physicians and a nurse practitioner under the direction of a preceptor physician and the medical director. Referrals to the psychiatrist or nutritionist is assessed during the initial interviews with the staff nurse, physician/nurse practitioner and case manager. Weekly multidisciplinary client conferences are co-led by the staff physician and psychiatrist. Other professional services include: psychiatric consultation, case management, benefit counseling and advocacy, psychological counseling, peer support and advocacy, nutritional assessment, and if desired, spiritual direction. Outpatient services also include pharmaceutical, laboratory and diagnostic procedures.

Patients are eligible for peer advocacy services. Peer Advocates assist HIV seropositive persons to provide increased access to medical care at St. Mary's Hospital. The Peer Advocates function as key members of the healthcare team. In this role, they work closely with the clients' (SMPM Clinic patients) case manager as a broad range of needs are identified and addressed for each client including, but not limited to, housing, food, clothing, practical and emotional support, and financial assistance. The advocates provide hands-on assistance to these individuals. They have been successful as indicated by increased patient morale, increased return for follow-up visits and decreased inappropriate use of the emergency room.

Patients also have access to an on-site part time Clinical Trials Specialist, who provides consultation to patients, physicians and staff concerning currently developed HIV medications available through clinical trials and expanded-use access.

The SMPM Clinic provides day and evening services to accommodate patients who are employed. Child care services are available in an existing playroom located in the SMPM Clinic.

The SMPM Clinic has a team of permanent paid interpreters that have language capability in Vietnamese, Cambodian, Laotian, Mandarin, Cantonese, and Spanish as well as French and German. Some members of the core program staff are fluent in Spanish.

Patients can access emergency room, acute inpatient and skilled nursing care and HIV dementia unit services as needed. Continuity of care is provided to hospitalized patients by a newly developed HIV consult service staffed by physicians and a nurse practitioner from the outpatient clinic. Additional subspecialty care in the areas of gynecology, cardiology, dermatology, neurology, allergy, endocrinology, orthopedics, radiation/oncology, ophthalmology, podiatry, ENT and cardiovascular surgery are available. Patients who require obstetrical services are referred to an attending St. Mary's Hospital and Medical Center obstetrician who has admitting privileges at California Pacific Medical Center, St. Luke's Hospital or Seton Medical Center.

*177 Ryan White targeted patients with HIV disease. Approximately 60 additional HIV infected patients are also being followed by the Sr. Mary Philippa Memorial Clinic (demographics not available). An average daily census of 10-15 HIV infected patients are hospitalized for acute illnesses at St. Mary's Hospital and Medical Center.

Funding Sources: General St. Mary's Hospital and Medical Center Funds and CARE Title I Supplemental

HIV HEALTH SERVICES PLANNING COUNCIL
SERVICE AREA PROVIDERS

Agency/Individual: ST. MARY'S HOSPITAL AND MEDICAL CENTER

Service Site: CARE UNIT, 4-SOUTH
PRIMARY MEDICAL CARE SERVICES, INSTITUTIONAL CARE, SKILLED NURSING

Target Population: PERSON WITH MODERATE TO SEVERE AIDS-RELATED DEMENTIA

Client Demographics: (Number Served/Percentage of Total)

Male: 23/100% Female: Zero

White: 17/74% African American: 3/13% Latino: 3/13%

Native American: Zero Asian/Pacific Islander: Zero

Service Description:

St. Mary's Hospital and Medical Center operates a 20-bed unit that provides care to individuals who have skilled nursing level needs and require a secure facility to accommodate AIDS-related dementia behavioral problems. This unit provides a stepped-down level of care for patients recovering from acute medical illness where the diagnosis of AIDS-related dementia has been established and is the primary diagnosis. Specific laboratory and diagnostic tests are required to assist in making a definitive diagnosis of AIDS Dementia Complex (ADC) as part of the admission review.

The facility accommodates both ambulatory and non-ambulatory patients. Staff are able to provide intravenous therapies, ongoing medical evaluations, behavioral interventions, and assure compliance with chronic drug regimens. Emergency medical care, specialized diagnostic and therapeutic services, and case management services are provided. The unit also provides a clinical site to test and develop behavioral interventions for ADC. Specific data to evaluate patient outcome is collected using a series of well-accepted rating scales which measure functional activity and neuropsychological impairment.

The CARE Unit is designed with an environmental approach to dementia care, creating an external structure for patients with advanced ADC who lose their ability to monitor, modify, or control behavior. Continuous assessment of appropriate individual stimulation level avoids worsening of confusion, agitation and fearfulness. Acute mental status changes precipitated by medical problems, such as medication side effects, nutritional deficiencies and dehydration are prevented, to the extent possible, by careful monitoring and early interventions.

The Care Unit is staffed for 5.9 actual labor hours, per patient day, with a mix of registered nurses, licensed vocational nurses and certified nursing assistants in a team nursing structure under the supervision of a nurse manager. The unit also provides the following medical and ancillary support staff: .5 FTE Medical Director, .5 FTE Psychiatrist, .5 FTE Clinical Nurse Specialist, .5 FTE Case Manager, .5 FTE Recreation Therapist, .2 FTE Occupational Therapist, and .3 FTE Physical Therapist.

Duration of stay is determined by level of care criteria. If a patient requires acute hospitalization, then the referring party will be responsible for the acute hospitalization of the patient. Patients may be hospitalized for acute care at St. Mary's if a bed is available and when approval is given by the insurance carrier. A bed may be held on the CARE Unit if the patient stabilizes.

Since its beginning, this Unit has provided care for 54 patients with AIDS dementia. These patients were predominantely comprised of a population of well-educated caucasian males who were living with family or friends prior to hospitalization for their disabling dementia. Most of these patients had advanced HIV disease with a mean CD4 count of 46, 45% had multiple HIV related complications and 35% had HIV dementia as their index diagnosis. Neuropsychiatric evaluations revealed that despite the presence of severe symptomatology, a majority of patients were able to be stabilized or rehabilitated, and 52% were returned to a less structured community setting after intervention on this unit.

Funding Sources: GENERAL ST. MARY'S HOSPITAL AND MEDICAL CENTER FUNDS, MEDI-CAL, MEDI-CARE, INDEMNIFICATION INSURANCE, HMO CONTRACTS AND CARE TITLE I FORMULA

Latino AIDS Services

Nydia Eva Rosales, Ph.D.
Clinical Supervisor
Mano a Mano Project

39 - 24th Street
n Francisco, CA 94110

Ph. (415) 647-5450
Fax (415) 647-0740

ervices Planning Council
ce Area Providers
cal Care Services Continuum

Nydia E. Rosales, Ph.D.

Agency/Individual: Mano a Mano Project or Latino Aids Services
Service Site: 1292 24th St SF CA 94110
Target Population: Latino(a) population w/Aids HIV

Client Demographics: (Number served/percentage of total)
Male 36 Female 9 Transgender 2

White _____ African American _____ Latino 100% = 47

Native American _____ Asian/Pacific Islander _____

Service Description: Mental Health Services consist of
Clinical Supervision to Case Managers / Counselors
Assessment/Evaluation - aim 100% of clients
Individual psychotherapy - to those who request it
or have greater need for self-understanding & support
Deep Relaxation/Visualization as part of individual
work for Group experience
Group Psychotherapy
Open ended, for all clients of Latino Aids Services
HIV+ emphasis on self-empowerment awakening
immune responses through hypnotic techniques

Funding Sources:

Ryan White

INSTITUTO FAMILIAR DE LA RAZA, INC.

Concha J. Saucedo M.
Executive Director

INSTITUTO FAMILIAR DE LA RAZA
MANO A MANO PROJECT

June 1992

Patient Demographics

Gender M = 36
F = 9
TG, TS = 2

Nationality/Place of Origin

Mexico = 16

So. America = 5
Caribbean = 11
U.S. Born = 4
Central American = 11

Patient Group

Gay Bisexual Males = 38
Gay Bisexual Males & IVDU =2

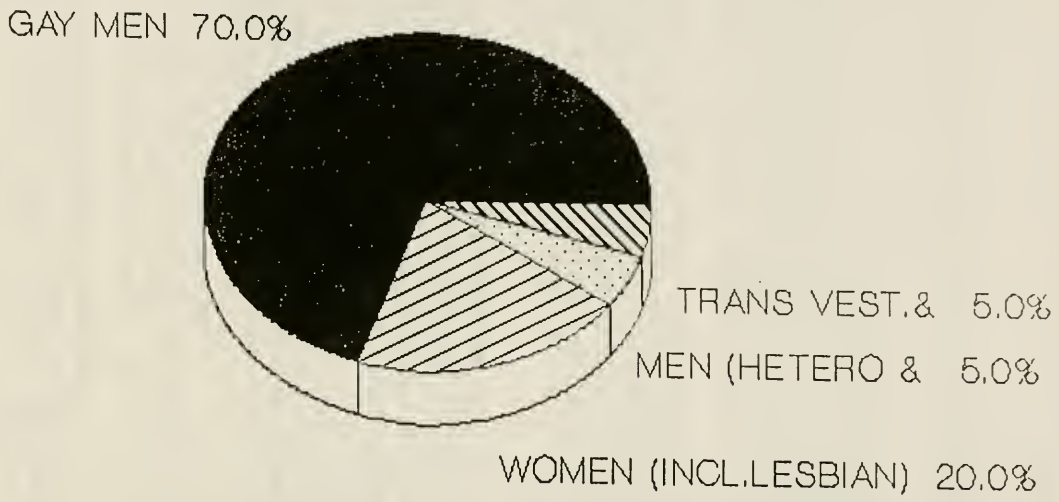
Heterosexuals = 7

Age Group
10-19 =1 1 male | 1 Female
20-24=5
30-39=30
40-49=7
50-59=3
60-69=1

Dx.
AIDS= 20
ARC= 25
HIV + Sx.= 2

SERVICE PROVIDED
Case Management/Counseling = 47
MENTAL HEALTH SERVICES
Clinical Supervision = 47
Psych. Evaluation/Assesment = 5
Individual Ongoing Psychotherapy
Weekly=10
Biweekly = 6
Total = 16
GROUP THERAPY (Psichoneuroinmunology) 2Hrs/Week.

MANO A MANO POPULATION
BY GENDER AND ORIENTATION



PROJECTIONS FOR F.Y. 92-93

SUMMARY

In September of 1991 The Mano a Mano project re-implemented the Psycho-Social Component of the Latino AIDS Services. As a result of the pressing need to establish a working model for providing practical and emotional support to Latinos affected by the AIDS epidemic, with emphasis in the area of mental health and to provide services that are integral and comprehensive as well as culturally sensitive.

This constitutes a "First Glance" at some of the data that has been complied during the first months of this effort, with the intention of developing a tool to help us asses our own needs, as well as our gains, and to help us mantain our goals and objectives in clear perspective.

With an accelerated rate of demographic growth, Latino women and men face an equally growing risk of HIV disease contagion. All efforts in prevention, education, research and intervention are not only necessary but indispensable, it is in this spirit that this work is put forward.

We hope to continue our service in the Latino community in San Francisco, to improve our abilities, expand our knowledge and skills, extend our compassion to all and thus, be better able to confront the demands that the future will impose on us as providers, members of our community, and as human beings.

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: University of the Pacific, School of Dentistry

Service Site: 2155 Webster Street, San Francisco, CA 94115-2399

Target Population: Indigent, Uninsured, or Underinsured Residents of San Francisco County

Client Demographics: (Number Served/Percentage of Total)

Male 750/95% Female 41/5%

White 555/70.3% African American 90/11.4% Latino 72/9.1%

Native American 10/1.3% Asian/Pacific Islander 18/2.3%

Service Description:

The University of the Pacific Dental School contracted with the City and County of San Francisco to serve the dental needs of 750 HIV-seropositive patients who are indigent, and uninsured or underinsured residents. The demand for dental care in the target population has been phenomenal. During the first year of CARE funding, we have served over 750 new patients.

The oral needs of HIV-seropositive patients are extensive. The oral cavity is the first site of some opportunistic infections, as the individual's ability to fight infections decreases over time. In addition, many of these patients have severe dental problems, including periodontal disease and dental abscesses. This drains their immune system of resources that are often badly needed to fight other infections. Through the contract funding, we have been able to improve the health of the oral cavity, preventing periodontal problems and resolving ongoing endodontic and periodontal infections.

In the advanced stages of HIV disease, some of the simple pleasures such as smiling and having a quiet dinner with friends have a remarkable effect on the quality of life. Removing dental decay and providing esthetic restorations, as well as removing hopeless teeth and providing an appropriate dental prosthesis, has greatly added to the comfort and health of our patients and allowed them these pleasurable times with friends and family. We have also been a resource for the emergency dental problems that occur, the resolution of which is necessary for the health and safety of the patients.

Demand for services has escalated at a rate which exceeds our current funding restraints. We will start the second year of our CARE contract July 1, 1992. Our patients that are currently active will renew as being on record on that date. Even if we assume a 20% attrition rate, due to the completion of dental needs or failure of the patient to return for needed dental therapy, we still project a 45-60% shortfall in funding, by the end of the second contract year. This is based on the current demand and need for oral health/dental care. This shortfall translates into a projected $180,000 need for additional funding.

We feel that these primary care dental services, which prevent medical complications in HIV-seropositive patients as well as improve their overall quality of life, deserve increased funding to meet the projected shortfall.

Funding Sources:

Ryan White CARE funds only

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: UCSF School of Dentistry - John C. Greene, Dean, represented by Harvey A. Brody, D.D.S., Director, AEGD Program

Service Site: Parnassus, Buchanan, & SFGH Clinics

Target Population: Patients reporting to the School of Dentistry

Client Demographics:* (Number Served/Percentage of Total)

Total HIV+ served 7/1/89-6/30/90: 2,599 patients

Male _____ Female _____

White _____ African American _____ Latino _____

Native American _____ Asian/Pacific Islander _____

Service Description:

The kinds of services were threefold: 44% general restorative, 26% diagnosis and oral pathology, and 31% surgical procedures. The breakdown was consistent with those services provided to our general population. The only significant difference in the delivery of care between our HIV positive and non-HIV infected group of patients was an increase in the percentage of diagnosis and oral pathology services to the HIV positive patients. In 1988-89, the first year for which we received Ryan Title II funds, approximately 10% of our 26,000 patients were HIV positive.

* Client demographics have not been maintained because of issues of confidentiality. UCSF School of Dentistry will be a participant in a national study to identify patient demographics including ethnicity and gender.

Funding Sources:

Ryan White Funds
State subsidy
Patient fees
    Private Insurance
    Denti-Cal
    Self-pay

HIV Health Services Planning Council
Services Area Providers
HIV Primary Medical Care Services Continuum

Agency/Individual: Family Service Agency of S.F.

Service Site: Various Private Practioners' Offices Throughout S.F.

Target Population: HIV+ Asymptomatic Clients and Clients Who Have an ARC AIDS Dx and Who Need Mental Health Services

Client Demographics: (Number served/percentage of total)

Male 117 (94%) Female 7 (6%) Transgender

White 101 (81%) African American 7 (6%) Latino 13 (11%)

Native American 1 (1%) Asian/Pacific Islander 2 (2%)

Service Description: This program is an expansion of the FSA/MIA Outpatient Program that has been providing mental health services to the severely disturbed medically indigent community since January 1, 1983. It utilizes a pool of 160 private psychologists and psychiatrists. Services have been funded by DPH/DMSF. This same pool has been made available to serve an additional 100 unduplicated HIV+ Asypmtomatic, ARC and AIDS clients with 1,264 hours of service as follows:

PSYCHIATRISTS will provide:

a) Psychiatric Evaluations, including Diagnostic Evaluations, and Evaluations for and Prescribing of Psychotropic Medication. (378 Hours/Units).

b) Crisis Mental Health Interventions including early identification of major stressors in the patient's life, assistance in problem-solving around identified areas of distress, and short-term supportive psychotherapy. The clinical assumption here is that the HIV+ status is, by definition, a mental health crisis for every patient. Further crises are faced by some portion of the target population with the development of symptoms and/or diagnosis of any AIDS related complex or AIDS. (200 Hours/Units).

PSYCHOLOGISTS will provide:

a) Neuropschiatric Evaluations via Neuropsychiatric Testing. This service targets dementia patients, and those in whom dementia is suspected. The evaluations indicate areas and extent of the neurological disability and consequent levels of functioning. They can be an extremely important part of the assessment of financial, health, and social/cultural needs of the target population. (412 Hours/Units).

b) Crises Mental Health Intervention. Same as PSYCHIATRISTS, above. (274 Hours/Units).

Funding Sources: DPH/DMSF and DPH/AIDS Office

MONTHLY REPORT — Fiscal Year

MIA OUTPATIENT PROGRAM

	# New Referrals	# New Open Cases	# Cases Closed	#Active Caseload	Clinical Units	Cost	Variance Per Month	Year to da Variance
BUDGET:					1264	$58,182	4849	
July							4849	4849
August							4849	9698
September	4			0	1	$69.00	4780	14,478
October	3	4		4	3	$207.00	4642	19,120
November	11	9	1	12	26	1330.00	3519	22,639
December	13	7	1	18	41	2065.00	2784	25,423
6 month averages;	5.2	3.3						
January	16	11	1	36	89	4379.00	470	25,893
February	16	4	0	40	94	4660.00	189	26,082
March	28	19	0	59	165	7756.00	(2907)	23,175
April	17	11	0	70	175	8558.00	(3709)	19,466
May	8	5	0	75	215	10559.00	(5710)	13,156
June								

Fiscal Year 91/92

Total:

CONTRACT TITLE: NEUROPSYCHOLOGY/PSYCHIATRIC EVALUATION INV. PERIOD: 5/1 - 5/31/92

CONTRACT NO: 83-07144 EXHIBIT NO: EXHIBIT A-1

CONTRACTOR: FAMILY SERVICE AGENCY OF SAN FRANCISCO

COST CENTERS	TOTAL UNITS CONTRACTED	PROVIDED THIS PERIOD	PROVIDED TO DATE	UNITS REMAINING
CRISIS MENTAL HEALTH INTERVENTION	474	100	402	72
PSYCHIATRIC EVALUATIONS	378	87	269	109
NEUROLOGICAL EVAL.	412	28	41	371
TOTAL UNITS	1,264	215	712	552

COST Personnel:	TOTAL BUDGETED	COST THIS PERIOD	COST TO DATE	AMOUNT REMAINING
Salaries	17,777	1,611.01	15,873.77	1,903.23
Fringe Benefits	2,844	263.26	2,444.17	399.83
Total Personnel	20,621	1,874.27	18,317.94	2,303.06
Operating:				
CONSULTATION-SUB CONTRACT	58,182	10,234.00	40,302.47	17,879.53
OFFICE SUPPLIES	200	0	309.57	(109.57)
POSTAGE	300	0	32.83	267.17
PRINTING & REPRODUCTION	300	181.10	281.92	18.08
ADVERTISING	214	0	0	214.00
Total Operating	59,196	10,451.10	40,926.79	18,269.21
Total Direct Costs	79,817	12,289.37	59,244.73	20,572.27
Indirect Costs	7,183	1,106.05	5,332.03	1,850.97
TOTAL COSTS	87,000	13,395.42	64,576.76	22,423.24

APPROVED BY: DATE: 6/18/92

Betty Abacan
Dept. Head/Controller
Administrative Services

MONTHLY PERSONNEL COSTS

INV. PERIOD: 5/1 - 5/31/92

POSITION TITLE	BUDGETED SALARY	SALARY THIS PERIOD	SALARY TO DATE	SALARY REMAINING
PROGRAM DIRECTOR	7,672	660.64	7,049.62	622.38
CLERK	10,105	950.37	8,824.15	1,280.85
TOTAL SALARIES	17,777	1,611.01	15,873.77	1,903.23
FRINGE BENEFITS	2,844	263.26	2,444.17	399.83

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: Jim Illig, CONTINUUM HIV DAY SERVICES

Service Site: 10 United Nations Plaza

Target Population: adults with AIDS and disabling HIV disease

Client Demographics: (Number Served/Percentage of Total)

Male 161/ 96% Female 7/ 4%

White 124/ 74% African American 25/ 15% Latino 15/ 9%

Native American 2/ 1% Asian/Pacific Islander 2/ 1%

Service Description:

Although adult day health care is listed as one of the "Other Primary Health Care Services", Continuum now provides some primary medical care through Dr. Ian Barlow of the AIDS Health Project (neuropsychiatric assessments, medication monitoring, crisis intervention). With the assignment of an AIDS specialist MD, this program could also provide the primary medical care that most of our clients now must find elsewhere in the public health system.

85% of Continuum's clients are low-income MediCal recipients, and the vast majority of them seek medical care at Ward 86, Tom Waddell Clinic, or other MIA outpatient clinics serving PWAs. Their primary care is often inconsistent and uncoordinated due to the difficulties our clients have in getting to appointments and the overwhelming burden of cases these providers treat. Our 3 nurses spend a great deal of time on the phone each day trying to coordinate treatments and discuss health status changes with the staffs of these clinics.

Since the goal of AIDS day health care is to focus all necessary health services for PWAs in one place, it makes sense that the program should include primary medical care. Dr. Eric Goosby provided on-site treatment and medical consultation for a time, but when he left SFGH, this community site was abandoned. If SFGH AIDS Services or DPH assigned a physician here, Continuum could relieve some of the overcrowding at Ward 86 and other public health clinics by providing routine medical care, pharmacy, laboratory and other services for 50-75 low-income PWAs now seen elsewhere in the system.

We have the license, staff and programming for ongoing health maintenance, and we have the space and skilled nursing support for primary medical care, as well. To facilitate this, and allow for MediCal fee-for-service billing, Continuum is now applying for a Primary Care Outpatient Clinic license from the Dept. of Health Services.

FUNDING SOURCES:

Fee-for-service	MediCal	23%	
	Private pay & VA	3%	
Govt. contracts	CARE/ DPH AIDS Off.	21%	($194,000)
	state Dept. of MH/ DPH CMHS	11%	
	state Dept. of Aging	8%	
Fundraising		35%	

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: San Francisco Community Clinic Consortium/Dennis Yamamoto

Service Site(s): Haight Ashbury Free Medical Clinic, Lyon Martin Women's Health Services, Mission Neighborhood Health Center, Native American Health Center, South of Market Health Center, Women's Needs Center.

Target Population: Medically underserved of San Francisco (homeless, uninsured, persons of color, poor,)

Client Demographics:

Male: 422/86% Female: 70/14%

White: 230/47% African American: 86/17% Latino: 130/26%

Native American: 32/7% Asian/Pacific Islander: 14/3%

Service Description:

The SFCCC through its member community health clinics provides medical and social services to HIV infected individuals. From May 1991 to March 1992, SFCCC clinics have provided 3,335 units of service to 492 unduplicated clients.

The range of services include outreach, health evaluation and monitoring(early intervention), primary care, case management and social services advocacy.

Also, each clinic along with early intervention primary care services has their own particular subset of services. For example, a) South of Market Health Center and Native American Health Center provide dental care for HIV infected individuals, b) Haight Ashbury Free Medical Clinic has podiatry, acupuncture, and psychiatry ancillary services, c) Women's Needs Center provides colposcopies, and d) Lyon Martin Women's Health Services conducts support groups for both HIV positive women and their partners/family and e)Mission Neighborhood Health Center provides clinical trials advocacy. This list is not inclusive.

The overall mission of SFCCC is to provide affordable, culturally sensitive health care to San Francisco's uninsured and underserved communities by acting as a central program management component, providing technical assistance and advocacy.

Funding Sources: SF Department of Public Health AIDS Office, Federal Ryan White Title III Funding, (These sources relate specifically to HIV infected people)

The San Francisco Community Clinic Consortium

1748 Market Street, Suite 205, San Francisco, CA 94102 252-7291

Providing access to affordable, culturally sensitive health care to San Francisco's uninsured and underserved communities

Lyon Martin Women's Services
Primary care for women by women

North of Market Senior Services
Medical & support services for the Tenderloin's multi-ethnic senior community

Mission Neighborhood Health Center
Comprehensive health care for the Latino community

San Francisco Community Clinic Consortium

- Central Program Management
- Technical Assistance
- Advocacy

lative American Health Center
Primary care and support services for Native Americans

St. Anthony's Clinic
Free multicultural primary care for uninsured/homeless families

South of Market Health Center
Health and support services targeting African Americans and Filipinos

North East Medical Services
Comprehensive health and support services for the Asian community

Haight-Ashbury Free Clinics, Inc.

Haight-Ashbury Free Medical Clinic
Free primary care and specialty services

The Women's Needs Center
Free woman-centered gynecology and family planning

SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM
Clinics providing HIV services

Native American Health Center
56 Julian, 621-8051
Buses: 14,22,49

Priority given to Native Americans.
Confidential HIV testing and counseling.
HIV primary medical care service.
Psychosocial intervention and case management.
contact person: John Pakula, M.D.

Lyon Martin Women's Services
1748 Market, Suite 201
565-7667
252-7499 TDD (for hearing impaired)
Buses: 6,7,8,71

HIV primary care services for HIV+ women.
Anonymous HIV testing and counseling.
Drop in support groups for lesbians with HIV.
General medical for women by women.
contact person: Rita Shimmin

Haight Ashbury Free Medical Clinic
588 Clayton St.
431-1716
Buses: 6,7,33,43 66,71,73

HIV primary care and treatment.
HIV case management.
Confidential HIV testing and counseling.
contact person: Bekki Kenlan

South of Market Health Center
55 Minna, 626-2951
(between Mission & Howard,6th & 7th)
Buses: 14,26

Primary health care to HIV- infected patients.
Medical drop-in Mon-Fri 8-10 am and 1-2 pm.
Confidential HIV testing and counseling.
contact person: Marilyn French-Speller RN

SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM
Clinics providing HIV services

Mission Neighborhood Health Center Buses: 22,33,53
16th. & Shotwell, 431-3212 or 552-3870

Comprehensive medical and psychosocial services to HIV infected individuals. Clinical trials information & advocacy.
HIV support groups.
Anonymous HIV testing and counseling.
La Clinica Esperanza-HIV clinic 6:00 - 9:30 pm Monday thur Friday.
contact person: Brenda Story

Women's Needs Center Buses: 6,7,33,43 66,71,73
1825 Haight Street, 221-7373
GYN and colposcopy services for HIV+ women.
Anonymous HIV testing and counseling.
No primary care services for HIV, however information and referrals are available.
Outreach to women at risk for AIDS.
contact person: Mary Ziady, FNP

North East Medical Services Buses: 15,30, 41,45
1520 Stockton, 391-9686

HIV primary medical care.
Confidential HIV testing and counseling.
Languages spoken by staff: Cantonese, Mandarin, Vietnamese, Burmese, Thai, Korean, East Indian.
contact person: Jamie Chau

North of Market Senior Services Buses: 5,19,31
333 Turk Street, 885-2274

Comprehensive primary health care services to HIV infected individuals. Comprehensive case management.
Confidential HIV testing and counseling.
Services limited to Tenderloin residents over the age of 55.
contact person: Lynn Holleuffer RN

South of Market Multi-Purpose Service Center Buses: 27,42
525 Brayant Street, 597-7759 shelter #
HIV outreach targeting the homeless population.
Information and referrals provided for a wide range of HIV/AIDS services for those who are HIV+ and for those at risk.
contact person: Michael Robinson SFCCC office #252-7291

Any questions, comments or concerns pertaining to any of the above clinics can be directed to Dennis Yamamto, M.S.W. HIV Coordinator at 252-7291.

7/92

The San Francisco Community Clinic Consortium

A 501(c)3 nonprofit association of community-based health centers. Founded in 1982.

Agency Activities

Grant Seeking

Manage centralized grant-seeking for health programs to be implemented at member clinic sites

Program Management

Provide centralized program and fiscal administration, monitoring, and reporting to funders

Technical Assistance

Assist member clinics with implementation, tracking, and evaluation of collaborative programs

Direct Services

Education, outreach, case management and referral

Advocacy

Advocate for improved access to health care for the city's underserved communities

Fiscal Agent

Fiscal agent for the Women's Cancer Network

Programs Administered

Health Care for Homeless People

Street outreach and clinic-based services:

- *Primary care*
- *Mental health*
- *Substance abuse treatment*
- *Health education and referral*
- *HIV risk reduction education*
- *Case management*
- *Food, clothing and hygiene items*

HIV/AIDS Programs

Population-specific:

- *Risk reduction education*
- *Antibody testing and counseling*
- *Primary care & health maintenance for HIV-positive individuals*
- *Outreach*
- *Case management*
- *Training for medical providers*

Substance Abuse Prevention

Two programs targeting high-risk teens and women of childbearing age:

- *Education/counseling*
- *Case management and support groups*
- *Peer counseling*

Smoking Cessation

For adult clinic users:

- *Life skills training*
- *Health education*
- *Medical staff education*

1748 Market Street, Suite 205 San Francisco, CA 94102 (415) 252-7291

HIV HEALTH SERVICES PLANNING COUNCIL

July 27, 1992

The Agenda and Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

HIV HEALTH SERVICES PLANNING COUNCIL

August 17, 1992

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

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17/92

HIV HEALTH SERVICES PLANNING COUNCIL
AUGUST 17, 1992
5:00 - 7:30 P.M.
HUMAN RIGHTS COMMISSION

Members Present: Sandra Hernandez, Marcy Fraser, Yvonne Frazier, Estela Garcia, Les Hanson, Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Jerry Windley, Mary Jane Wood

Members Absent: Reggie Williams, Pat Christen, Maria Church, Jaime Geaga, Karen Hembry, Gifford Leoung, Steve Lew, Pierre Ludington, Darol Nance, Patricia Underwood, Sylvia Villareal

Staff Present: Bill Haskell, Valerie Dorr, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review and Approval of Minutes

The Minutes of the July 27, 1992, Planning Council meeting and the August 5, 1992, Public Hearing were approved.

III. General Announcements

Sandra Hernandez apologized for the meeting being moved from 25 Van Ness to the Human Rights Commission. Dr. Hernandez explained that due to a labor dispute between the City and the janitorial service for the building, she had the meeting moved to avoid having Planning Council Members cross a picket line. Dr. Hernandez extended her thanks to Norm Nickens of the Human Rights Commission for the use of their offices.

Dr. Hernandez next made the announcement that she would be leaving the AIDS Office to take up the directorship of Community Public Health Service (CPHS). Dr. Baxter has implemented a reorganization of the health department that consolidates mental health, substance abuse, community public health and AIDS services in a more functional manner. Flo Stroud will oversee CPHS, the AIDS Office, and the Department of Mental Health, Substance Abuse and Forensics (DMSF). Dr. Hernandez and Jeff Jue, head of DMSF will report to Ms. Stroud. Dr. Hernandez' new position will entail being the Director of CPHS as well as the district health officer position. CPHS is the division that oversees the 11 health centers and various bureaus and programs such as epidemiology, family planning and perinatal services.

There will be an open recruitment for the directorship of the AIDS Office. Dr. Hernandez will not be moving to CPHS until her replacement is found as she does not want to leave the AIDS Office with an Acting Director. Dr. Hernandez explained that there will be community representation review of the applications with the department subsequently performing its

selection process. The earliest Dr. Hernandez' replacement would be in place is October 1st, a more likely date is November 1st.

Dr. Hernandez stated she will continue as co-chair of the Planning Council.

The second announcement from Dr. Hernandez was a presentation of the "Proposed Principles of Health System Reform" being formulated by the Health Commission. Dr. Hernandez explained that this is a **draft** document. The Health Commission is taking this proposal to all of the advisory bodies to DPH and asking for comments.

Laura Thomas stated that the document needed to address two issues i) experimental clinical trials and non FDA approved drugs (expanded access); and ii) alternative or complimentary therapies/treatments.

Marcy Fraser stated that the document needs to address the need for more public private partnerships. There must be reform in both sectors for true health system reform.

Michael Shriver announced that there will be a lobbying effort by CARE Title I and II representatives as well as representatives for Prevention and Research in Washington, D.C. on September 8 & 9. On September 14 & 15, the Cities Advocating Emergency AIDS Relief (CAEAR) consortium will lobby the Senate.

IV. Housing Opportunities for Persons with AIDS (HOPWA) Review/Update

Bill Haskell presented the Planning Council with an update on the HOPWA funds. Mr. Haskell stated that the regulations for HOPWA were issued on July 20, 1992. The regulations were less restrictive than had been thought. The San Francisco EMA received less monies than had been previously estimated. The EMA received $3,635,000 not $4.1 million. The money was proportionally distributed within the EMA (San Francisco, Marin and San Mateo) based on the number of living PWAs as of September 30, 1991, the allocation date used in the HOPWA legislation. San Francisco has 84% of the living PWAs in the EMA and Marin and San Mateo each have 7%. Therefore, respectively the amount of funds for each county is $3,126,100; $254,450; $254,450 .

The HOPWA application is due by September 30, 1992. The regulations require that the lead agency and unit of local government applying for the funds be approved by 50% of the Community Development Block Grant groups in the EMA. To meet this mandate, a meeting was held on August 12, 1992, in the San Mateo AIDS Office. The CDBG groups agreed to dividing the funds by county based on number of living PWAs and that San Francisco should be the unit of local government applying for the funding. The San Francisco Redevelopment Agency will oversee the process, as the lead agency designated by Mayor Jordan.

Mr. Haskell reported that there will be a rolling review of applications by Housing and Urban Development (HUD). This $3,635,000 portion of the HOPWA funds is similar to the CARE Formula monies and is not competitive. A portion of the HOPWA monies is competitive under the Special Programs of National Significance. San Francisco is eligible to apply for these monies. Similar to the Title II piece of the CARE Act, California as a whole is entitled to $1,106,000. The State has yet to announce how it will allocate its funds.

v. CARE Formula Rollover Budget

Valerie Dorr spoke on the close-out of CARE Formula funds for Y01. (See enclosed handout.) The close-out for Y01 CARE Supplemental has yet to be completed. The AIDS Office Fiscal Services Branch estimates that there may be up to $1.5 million in savings from the Y01 Supplemental grant.

Ms. Dorr explained that the first page of the handout is the $1,108,651 final budget for the CARE Formula Rollover monies. She noted that the original amount set aside by the Planning Council for a consultant for the copayment system will be split between CARE Formula and Supplemental savings.

Ms. Dorr went on to explain that the second page contained the original amount proposed by the Planning Council for usage of the $500,000 for the AIDS Drug Program (ADP) and a suggested revised budget. The primary changes are in the amount for advertising, and an increase in monies for the SFGH pharmacy. The amount proposed for advertising was reduced from $50,000 to $10,000. The amount for SFGH's pharmacy was raised from $184,000 to $303,876. This increase in the pharmacy was to cover the uncompensated cost of psycho tropic drugs for dual diagnosed patients. Mental health programs are currently running a $250,000 deficit for psycho tropic drugs.

Michael Shriver stated that the only change he would make is to the $10,000 for advertising. Mr. Shriver stated he felt that $10,000 was too little to perform an adequate campaign to raise consumer awareness of the ADP. Eric Rofes agreed that the amount seemed too little. The Planning Council had wanted a consumer oriented high-visibility campaign.

A) The following motion was approved by the Planning Council:

To approve the proposed changes to the AIDS Drug Program budget with the amounts for ADP advertising being $50,000 and SFGH Pharmacy being $263,876.

VI. Review of the 70% Rule

Bill Haskell reminded the Planning Council of its previous decision that no more than 70% of an agency's budget could be CARE funds. The original reason for the Planning Council's decision on the 70% rule, was the concept that agencies must have diverse funding streams to assure continuation of the program or agency if one funding stream was reduced or lost. Jon Dean Green reminded the Planning Council that for agencies receiving Title II monies, the 70% rule is a requirement set by the State.

Currently there are agencies that are either not in compliance with this rule, or very close to not being in compliance. The AIDS Office is requesting Planning Council guidance for questions regarding the 70% rule. In cases where an agency is markedly out of compliance with the rule, the AIDS Office has three options, i) terminate the contract; ii) reduce the contract amount to bring the agency into compliance with the 70% level; or iii) not act on the lack of compliance. The AIDS Office inclination is to lower the amount of the contract to bring an agency into compliance and/or encourage an agency to engage in fundraising.

Mr. Haskell stated that this matter was being brought to the Planning Council's attention because a recent audit showed one agency dependent upon CARE funds for 95% of its budget. In essence, CARE funding supported the entire agency.

Q-What is the size of the contract being discussed? A-Between $120-130 thousand.

Estela Garcia stated that the 70% rule is more of an issue for small agencies than large agencies. There are individual issues for each agency, and different requirements for how to get the agency onto the right track.

Sandra Hernandez stated this is an agency that has had problems and received large amounts of technical assistance. If the decision of the Planning Council was to decrease the contract, the AIDS Office would negotiate a reasonable reduction in service.

Jon Dean Green stated that in reviewing the requests for funding in Y02, proposals that did not meet the 70% rule in their proposal were automatically disqualified. He asked the Planning Council to keep this in mind as a matter of equity.

Michael Shriver proposed that the agency be given 30 days to develop a plan of action and 60 days to raise the funds. If at the end of the 90 days, the agency did not have the requisite amount, its contract should be reduced.

Laura Thomas stated that there are two issues at hand. What is in the best interest for persons being served by the agency, and what it in the best interest of the agency. Ms. Thomas asked if the agency was attempting a good faith effort at fund raising?

Q-What is the staff recommendation for handling this matter? A-To ask the agency to develop a timeline for a plan of action and perform fundraising. If at the end of that time there is not significant progress, to reduce the contract.

Eric Rofes stated that the Planning Council should set a policy and examine individual cases as they occur, if necessary. Parameters must be set and applied fairly and evenly across the board. Technical assistance can be given to agencies, but that does mean that agencies will either accept or use the technical assistance.

Michael Shriver stated that the Planning Council did not consider Y02 applications that were out of compliance with the 70% rule. The agency knows it is out of compliance; it has been given technical assistance. The Planning Council must set a firm deadline and clear expectations. The Planning Council has a duty to maintain equity.

B) The following motion was passed by the Planning Council:

For agencies not in compliance with the 70% rule, a directive should be issued requiring that within two weeks a plan for compliance with the 70% rule be submitted to the AIDS Office. After 90 days from the date of the directive, if the agency is still out of compliance with the rule, its contract should be appropriately reduced.

Sandra Hernandez stated that the above discussion brought up the next question, that of technical assistance. Should the contract with the Support Center be specific in naming agencies and the type of technical assistance they should receive?

Estela Garcia stated that a primary question is how to deliver technical assistance in such a way that agencies can successfully use the information and skills. Ms. Garcia pointed out that if there are concerns raised at the time of a monitoring of a contract, the review team can require technical assistance as an intervention.

Eric Rofes pointed out that there is only so much technical assistance that can be performed with agencies. There comes a point where continued hand holding goes beyond technical assistance and becomes codependency.

Mary Jane Wood stated she was involved with an agency that was not meeting its contract obligations. AIDS Office staff spoke to the Board of Directors of the agency. The Board subsequently realized changes needed to be made, and they were. Ms. Wood stated that the agency might not exist today without the intervention of the AIDS Office. There must be accountability.

VII. Discussion of Consumer Public Hearing Information

Sandra Hernandez stated that several messages were heard at the Public Hearing held on August 5, 1992, for consumers of HIV services. These included: 1)budget cuts are effecting the lives of clients, 2) care needs continue to exist at Peter Claver, 3) the need for expansion of food/nutrition programs, and 4) the need for mental health services.

Yvonne Frazier stated she was impressed with the turnout. Not only were there a number of clients, but many were quite ill and they waited in the cold to make their testimony.

Jerry Windley stated it was the best Planning Council meeting he had attended. It put the services into perspective and gave the Planning Council an opportunity to hear from consumers.

Sandra Hernandez stated that the Planning Council will try to rotate meetings out of the office of a more regular basis and advertise where the meetings will occur. This will give more people the opportunity to attend and make public testimony.

VIII. Planning Council Schedule

The meeting schedule for the next three weeks is as follows:

August 24	regular meeting
August 31	canceled
September 7	canceled
September 14	return to weekly meetings

CARE ROLLOVER BUDGETS

Year 01--Formula

SFDPH		$443,935
Health Center #1/Evening Clinic	$107,077	
Tom Waddell Clinic	$105,795	
Special Programs for Youth	$10,000	
SFGH	$170,285	
TB Control	$50,778	
Contractual Services		$36,000
SF Suicide Prevention	$36,000	
(Youth Services)		$269,367
Shanti Project (Housing)	$151,337	
Catholic Charities (Housing)	$48,633	
UCSF/AHP/ASAP (Subst Abuse)	$69,397	
CBO One-Time Expenditures		$290,000
San Francisco Food Bank	$11,500	
Visiting Nurses & Hospice/CPMC	$49,856	
SF AIDS Foundation	$49,050	
AIDS Emergency Fund	$50,000	
Shanti Project	$20,000	
AIAI	$8,830	
ALRP	$38,624	
Walden House	$30,810	
Continuum	$31,330	
Consultant for Copayment System	$45,094	$45,094
SFDP (Personnel COLAs)		$24,255
CMHS--Crisis Supplemental	$18,912	
DMSF-Forensics	$5,343	
TOTAL		$1,108,651
Total Available	$1,108,651	$0

Year 01 -- Supplemental

AIDS Drug Program (Original Budget Approved by PC)		$500,000
Decentralization of ADP	$150,000	
Advertising	$50,000	
SFGH Pharmacy	$184,000	
Home Infusion Equipment	$116,000	
AIDS Drug Program (suggested revised budget)		$500,000
Decentralization of ADP*	$96,218	
ADP Advertising*	$10,000	
Medication Delivery	$35,000	
Pharmacy (SFGH/Psychotropics)	$303,876	
Copayment Consultant	$54,906	
Amount Remaining		$0

* Amounts actually committed

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Proposed Principles for Health System Reform

1. Universal coverage: Health system reform must guarantee universal coverage and access for all people who live in California and in the United States. *While incremental improvements may be necessary*, the goal of any plan must be universal access for all.

2. Role of public health departments: Public health departments provide essential population focused, community health promotion and disease prevention services that are not included as part of individual health care benefits through insurance coverage. Examples of these services include disease control, health education, public health nursing services, and environmental protection services. These services must be recognized and adequately funded in any health system reform plan.

3. Role of public sector providers: Even under the most comprehensive national plan, public sector providers will be essential to any health care delivery system. This is for at least three reasons: First, the public sector must always be ready to respond to health care crises, such as the AIDS epidemic, when the private sector might not respond quickly enough. Second, the public sector must be available to provide services to those who do not have access to other providers. Finally, there will always be individuals who fall through the cracks of any so-called comprehensive plan. SFDPH believes it is absolutely essential to provide access for persons who are not able to receive appropriate health care services in other ways through the preservation of a strong and well-financed institutional safety net.

4. Comprehensive benefits: There must be a guaranteed broad-based benefit package that emphasizes coordinated preventive and primary care services for individuals. Covered services must include disease prevention and health promotion programs. *The plan should also include specified programs currently provided by public health departments, including mental health, family planning, long-term care, and substance abuse services.*

5. Payment mechanism: There must be a uniform payment rate for all patients for comparable services, with the costs of medical education and education for other health professions considered explicitly.

6. Cost containment: Health reform must include a package of cost containment measures to control operating and capital expenses because excess costs ultimately limit access to services. These measures should be based on appropriate regulatory provisions and should cover all components of the health system, without creating barriers to appropriate care. *Appropriate cost controls include evaluations of technology and procedures, resource planning for distribution of capital and medical technology, and global budgeting.*

7. Financing: The health system should be financed through *a combination of progressive financing mechanisms that could include tax incentives, broad-based taxes, premium base approaches and reasonable co-payments.* Any reform strategy should preserve and enhance all additional sources of revenue, including the maximization of federal financial participation.

8. Quality assurance: There must be mechanisms and safeguards to ensure effective and efficient organization of services and high quality care.

9. Development of the health workforce: Comprehensive health system reform must include support for the education and training of health care workers to ensure: (1) adequate financing, (2) appropriate supply and distribution of workers, geographically and across specialties, and (3) appropriate representation of all cultural and ethnic minorities in the health care workforce.

10. Reform of current private insurance marketplace: Any plan that continues to rely on the private insurance market must make the following reforms: (1) reinstatement of community rating, (2) guaranteed issuance and guaranteed renewability, (3) elimination of pre-existing conditions limitation, and (4) fraud control. Reform should also eliminate the duplicative administrative costs of a multi-payor, multi-eligibility system.

11. Ongoing planning and evaluation with consumer communities and providers: To ensure accountability to providers and consumer communities, there must be mechanisms to ensure ongoing planning and evaluation of the system.

Attachment A

HIV HEALTH SERVICES PLANNING COUNCIL

August 24, 1992

The Agenda of this meeting is missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

August 24, 1992

4:30 - 7:00

Members Present: Sandra Hernandez, Marcy Fraser, Yvonne Frazier, Estela Garcia, Jaime Geaga, Les Hanson, Gifford Leoung, Steve Lew, Kent Macdonald, Scott Miller, Mike Shriver, Laura Thomas, Jerry Windley

Members Absent: Reggie Williams, Pat Christen, Maria Church, Karen Hembry, Pierre Ludington, J.B. Molaghan, Darol Nance, Bob Nelson, Elliot Ramos, Eric Rofes, Pat Underwood, Sylvia Villareal, Mary Jane Wood

Staff Present: Bill Haskell, Valerie Dorr, Jon Dean Green, George Staub (CSAS)

I. Roll Call

Roll Call was taken as above.

II. Review and Approval of Minutes

Approval of the August 17, 1992, minutes was postponed to September 14, 1992.

III. General Announcements

Yvonne Frazier stated there was discussion in Sacramento to eliminate outpatient methadone maintenance as an optional benefit under MediCal. This would be a $1.8 million reduction in funds and would eliminate ~2,800 treatment slots in the state and over 400 treatment slots in the City and County of San Francisco. (See enclosed handout.)

Kevin Shelley, President of the San Francisco Board of Supervisors, spoke to the Planning Council on the State budget. (See enclosed handout.) Supervisor Shelley stated that the City expects to take a $50-80 million cut in funds from the State. The State is considering allowing counties not to have to provide General Assistance (GA). San Francisco is the only Bay Area county that would continue to provide GA. If this occurs, the City would become a magnet for health care.

Supervisor Shelley stated that the only source of revenue the State is considering allllowing local governments to use to make up for State cuts is a raising of sales tax. This is not a ready alternative for the City as it already has the highest sales tax in the State.

Supervisor Shelley indicated that he did not expect the AIDS Office itself to take a large percentage of the cut, but services that might be cut including health care, mental health services etc. would effect care for persons with HIV.

Q-What contigency plans are the Board of Supervisors examining for revenue generation? A-It takes 6 votes to pass a revenue package. If there is no consensus between the Board and the Mayor, then it takes 8 votes for an override of a mayoral veto. This 8 vote requirement is

more difficult to achieve. Supervisor Migden is examining different means of revenue generation that would not be considered taxation.

Q-Is the Mayor firm on his no new tax stance? A-The Mayor has stated he will not add any further taxes. His decision will probably be based on the position the business community takes.

IV. Revised Supplemental Budget

Valerie Dorr presented the revised CARE Supplemental budget. Ms. Dorr stated that the Supplemental budget has been finalized now that all contracts are let. Some programs did not contract for as much money as available. This money has been tentatively reallocated by the AIDS Office pending Planning Council approval. Ms. Dorr stated there are three changes to the revised budget: 1) item number 4 (CMHS) has the cost of living allowances included; 2) item number 62 (the Uniform Reporting System) has been added by HRSA to the Supplemental grant; and 3) item number 64 (probate conservatorship) is being proposed to be added, as it was previously scheduled to be funded under the General Fund and then subsequently was cut.

Bill Haskell referred Planning Council members to letters sent to the AIDS Office regarding probate conservatorship. (See enclosed handout.) Mr. Haskell explained that when the St. Mary's skilled nursing facility for clients with dementia was created, the AIDS Office assured St. Mary's that a probate conservatorship program would be started. The Office of the Public Guardian provides probate conservatorship for the elderly in San Francisco, but does not have the capacity to take on clients with HIV. Mr. Haskell stated that the AIDS Office is proposing piloting a probate conservatorship program to examine the costs of providing the service. The pilot program would be supported from January 1, 1993 - June 30, 1993 with CARE funds.

Q-Is the budget of $66,479 based on the left over amount of CARE Supplemental funds or is it based on a real cost? A-Both. That is the left over amount, but the original general fund proposal was for $70,000.

Q-Could the program be up and running by January 1, 1993? A-Yes.

Sandra Hernandez explained that this program would have to be covered by the General Fund in the coming fiscal year if it is approved by the Planning Council and not picked up by CARE in Y03. These clients once placed on probate conservatorship cannot be removed from it.

A) The following motion was passed by the Planning Council:

To approve the revised CARE Supplemental budget.

V. Review of Citywide Substance Abuse Treatment Services

George Staub, Community Substance Abuse Services (CSAS), gave a brief overview of the relationship between the AIDS Office (AO) and CSAS. Mr. Staub also accounted for the current AO/CSAS contracts. (See enclosed handout.)

Allonzo Gallaread/Continuum HIV Day Services

(See enclosed handout.)

Q-How understaffed is the substance abuse program at Continuum? A-1 or 2 full time equivalents (FTE) would reduce the number of persons denied service due to issues of client management. It would also help reduce client recidivism in that clients would receive more one-on-one staff time.

Stephen Manning/18th Street Services

(See enclosed handout.)

Mr. Manning stated that 18th Street Services currently has a 5-6 week waiting period. 18th Street Services is changing the entry requirements of the program to reduce the waiting time. Previously, a client had to have a clinical intake to enter the program. The program is being changed so that the point of entry into the system is a series of drop-in support groups.

Q-Are clients primarily gay/bisexual? A-Yes. Clients who are men who have sex with men, but do not self-identify as gay or bisexual would probably feel uncomfortable at 18th Street Services. 18th Street Services has an active referral process for clients to meet clients varied needs.

Q-What are the demographic distinctions between street outreach and persons coming into the facility for treatment? A-For people coming into the facility 75% are white and 25% are people of color (POC). The POC are equally divided between Latinos and African Americans with a few Asian/Pacific Islanders and Native Americans. For street outreach, 50% of clients are POC, equally divided between African American and Latino with a few Asian/Pacific Islanders and Native Americans.

Q-What percentage of clients are youth? A-Of 150 clients, 30 are < 28 years old.

Q-In last year's contract, 18th Street Services had a shortfall in the number of youth it served. Why? A-The younger the client is, the less comfortable they are in using the service. Service usage is related to age. Youth are not used to going to a facility to seek service. This is a learned behaviour. Street outreach is a way of reaching youth. 18th Street also gives youths referrals to other agencies if the youth feels they would be more comfortable someplace else.

Coletta Reid/Iris Institute

(See enclosed handout.)

Ms. Reid stated that the Iris Institute (formerly the Women's Institute for Mental Health) just received its CARE monies in July, 1992. The Iris Institute decided to apply for funds when four women with HIV entered its substance abuse treatment services. As the women became more vocal in their ongoing groups, other women without HIV became resentful of the time discussion of HIV took in the groups as the women who were HIV- wanted to discuss substance abuse issues. Last year, the Iris Center served ~330-350 women. 50% of these women are POC, 2/3 are African American and 1/3 are Latina. The day program at the Iris Center for pregnant and post-partum crack addicts was used as a model for the HIV program. Referrals come from other AIDS Service Organizations (ASOs), women oriented agencies, and substance abuse treatment centers. CARE monies pay for acupuncture, pre-treatment groups, ongoing recovery and detoxification, and aftercare. Other services are provided for with CSAS monies--therapeutic child care, family counselling, individual therapy and a parenting group.

Q-How do Iris Center clients access HIV testing? A-The Iris Center has a contract with Lyon-Martin Clinic for medical services. Women can go to Lyon-Martin or Mission Neighborhood

Health Center. The Iris Center has some concerns around testing for women in the early stages of recovery. A primary concern is women testing positive going back to substance abuse.

Q-Does the Iris Center provide transportation? A-The Iris Center has $7550 for a van. They are in discussion with Shanti to lease a van. Transportation would make a great difference in the number of women using Iris Services.

Q-How many women does the Iris Center expect to serve? A-They are planning to do outreach to 90 women, to intake 45 who will attend some sessions of the program with 30 women entering ongoing recovery. The program for crack addicts was the model upon which the numbers are based.

Steven Batki/SFGH Substance Abuse Services

Mr. Batki stated this is a new CARE funded program that was started in July, 1992. CARE monies added treatment slots for HIV+ persons to the programs for stimulant outpatient program (STOP), methadone treatment, and crack/cocaine. Medical and psychiatric services are provided. 2/3 of HIV+ substance abusers require psychiatric services due to organic disorders. 80% of STOP are African American. 50% of the methadone/opiate program are POC. Of the 190 people in the methadone program, 115 are HIV+. This high number is due to the preferential entrance design of the program for persons with HIV. There is a 60% seroprevalence in SFGH with ~15% seroprevalence in the general substance abuse community.

Q-What are the psychiatric services provided? A-Psychotherapy, diagnosis of organic disorders and medication management are the three primary services. 65% of the HIV+ persons in treatment need psychiatric services. 14% have psychotic symptoms and 15% have neurocognitive deficits.

Barry Lawlor/Haight Ashbury

This is a new CARE funded program that began in July, 1992. 50% of the clients seen are mentally ill, the number is higher for persons with HIV. 1 in 9 clients seen have HIV. Haight Ashbury has both blinded and confidential testing. CARE is funding a full time psychiatrist, but does not stretch far enough to cover psycho tropic drugs. A doctor has been hired and is seeing patients three days a week. The goals of the program are to provide full psychiatric screenings to 150 persons and retain 100 with medical stabilization of these clients. Mr. Lawlor stated that the primary indicator for shared needles among intravenous drug users (IDUs) is depression. Ameliorating depression therefor reduces needle sharing.

Jeff Presement/Walden House

(See enclosed handout.)

Carrie Graham/Harbor Light-Salvation Army

Harbor Light is a new CARE funded program that began in July, 1992. The program is for persons with drug and alcohol treatment needs. It has three parts: a social model of detoxification (25 beds); drug and alcohol recovery program (20 beds); and a residential component for 6 months to 1 year. CARE pays for 10 beds at the facility. The bulk of the services are detoxification and primary drug treatment.

Q-How many unduplicated clients will be covered by CARE? A-20 clients in the 10 beds.

Q-Is this the first time Harbor Light has provided HIV specific services? A-Yes.

Q-How is Harbor Light assuring services to sexual minorities? A-Harbor Light is aware of past problems around service to gay and bisexual men. It is performing inservice training to the staff and residents of the program to address the issue.

Yvonne Frazier/Community Substance Abuse Services

(See enclosed handout.)

Anne Welsh/AIDS Indigent Direct Services (A.I.D.S)

A.I.D.S. provides mental health and substance abuse therapy to indigent persons in the Tenderloin and South of Market area who have ARC or AIDS. A.I.D.S. provides services at its administrative offices and at the Ambassador Hotel. Clients are 65% lesbian, gay, bisexual, transgender. 60% are African American, 30% white and 10% Latino/Native American. The services A.I.D.S. provides are for persons who are unable to access substance abuse treatment elsewhere. For example, services are provided to the previously incarcerated who are unwilling to enter residential substance abuse treatment programs as the residential programs are too reminiscent of prison. A.I.D.S. provides individual and group counselling. Ms. Welsh stated that she attempts to refer clients to long term treatment where appropirate. Much of Ms. Welsh's initial work with clients is in trust building for clients to reach a point where they feel safe to divulge information and seek treatment. Sometimes it all begins with the card games she holds for clients. They come initially for the game and stay for counselling.

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SUBSTANCE ABUSE TREATMENT PROGRAMS

HIV HEALTH SERVICES PLANNING COUNCIL
8-24-92

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AGENCY: CONTINUUM HIV DAY SERVICES
SERVICE SITE: 10 United Nations Plaza, at 7th & Market Sts.
TARGET POPULATION: adults with AIDS and disabling HIV disease
CLIENT DEMOGRAPHICS: (FY 91-92)

Male:	194 / 96%	Female:	8 / 4%
White:	148 / 73%	African American:	30 / 15%
Latino:	18 / 9%	Asian/Pacific Isl.:	3 / 2%
Native American:	2 / 1%		

SERVICE DESCRIPTION:

A $41,800 CARE Supplemental grant funds a small component of Continuum's AIDS day health program, providing the equivalent of clinic/outpatient care in a daytime community setting. The one funded Substance Abuse Counselor must coordinate services to an estimated 60% of our PWA client population with complicating alcohol/drug abuse problems.

Because of the prevalence of substance abuse among our center's clients, Continuum has twice proposed to expand the CARE funding to enhance this service component. Our original proposal in Jan. 91 was cut 65% to the present level, and another proposal in Dec. 91 was rejected on technical grounds, even though Continuum's aftercare services have proven to be effective.

To extend the substance abuse treatment capacity of this program, the funded specialist works with a multi-disciplinary day treatment team of clinicians and para-professionals to identify and serve all of the AIDS/substance abuse clients in the ADHC program. He has trained a Program Assistant with recovery and counseling experience to work with him, and they co-lead substance abuse groups which have been expanded to 3 times/week at client request. Like the rest of the program staff, both also carry a caseload of clients with significant addiction problems.

The success and cultural competency of this service is largely due to the skills and experience of Alonzo Gallaread, the Substance Abuse Counselor. As an African-American male in recovery with many years' experience in AIDS/substance abuse treatment, he brings unique strength to this program.

Clearly, this component needs more staff with skills and experience in substance abuse treatment. A contract expansion to intensify these services would provide more of the recovery support Continuum's members need to live clean-and-sober, with AIDS, in the community.

FUNDING SOURCES:

Fee-for-service	MediCal	33%
	V.A. and priv.pay	2%
Govt. contracts	DPH/AIDS Off. CARE	19%
	DPH/DMS state grant	9%
	State Dept. of Aging	1%
Fundraising, foundation grants, donations		28%

HIV Health Services Planning Council
Service Area Providers

Agency/Individual: 18TH STREET SERVICES

Service Site: 217 Church Street (At Market), San Francisco

Target Population: Gay and bisexual men of all ages and colors whose lives are at risk because of substance abuse.

Client Demographics: (composite estimate based on 900 unduplicated clients per year in Clinic and all duplicated client contacts served by street-based outreach work).

Male: 99.9% Female: .1%

White: 63% African American: 15% Latino: 16%

Native American: 3% Asian/Pacific Islander: 3%

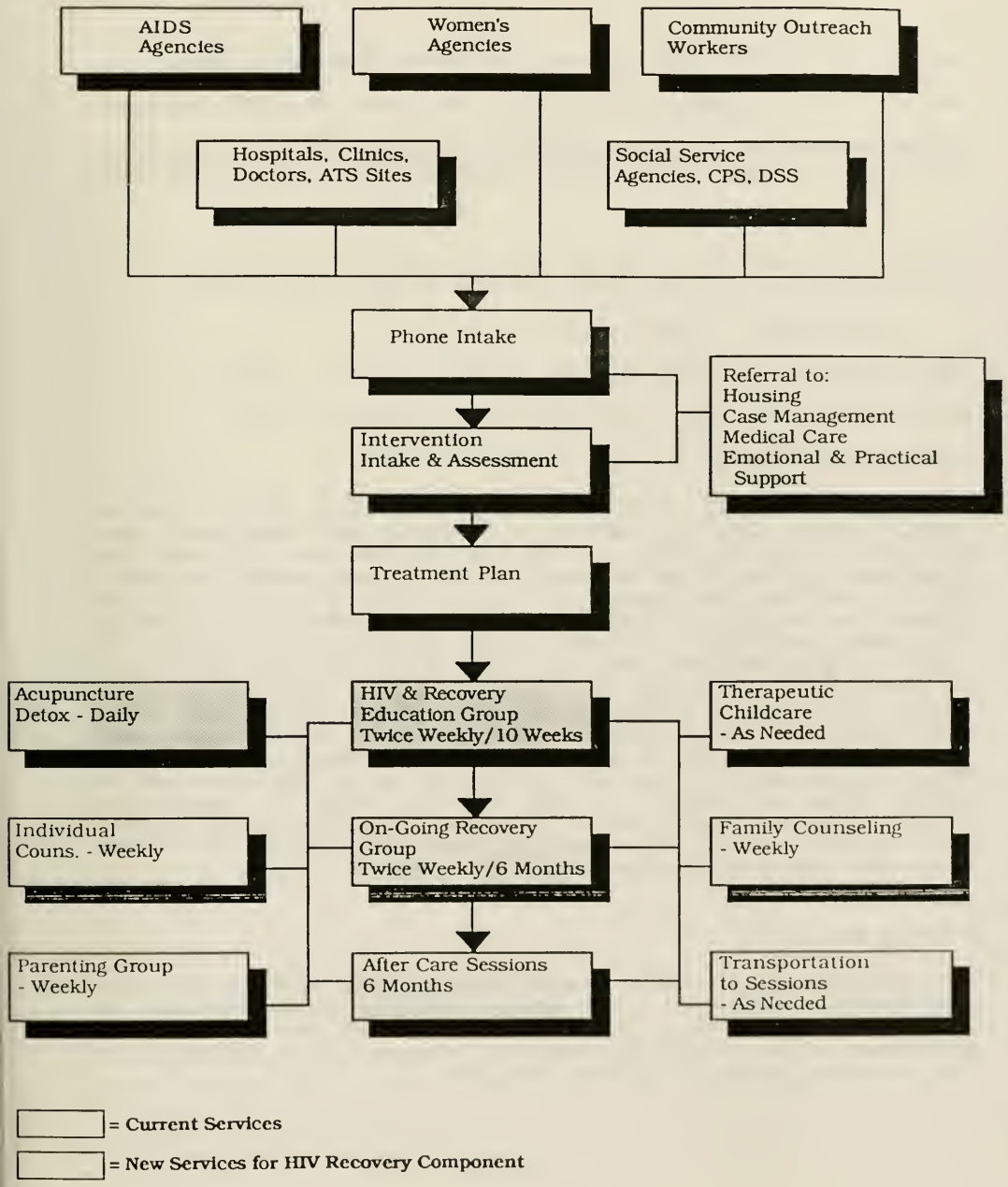
Service Description:

OUTPATIENT SUBSTANCE ABUSE TREATMENT CLINIC with staff of 10 provides group and individual recovery counselling program focussed on behavior change in context of life issues attached to addiction. CARE-funded program provides substance abuse counselling to 180 HIV affected Latino, Youth (18-27) and Aftercare clients. Volunteer-based pre-assessment support, clinical assessment and individual counselling match, with graded programs of early and continuing recovery, with aftercare option. Supplemented by open ongoing support groups for African American, Latino, Transgender, Youth and Longterm Recovery. HIV assessment and counselling integral to all components of program. To reduce average 5-6 week waiting period for treatment, developing pilot program of intern-facilitated drop-in support groups as initial recovery support option, targetted to begin in October 1992.

STREET-BASED CASE MANAGEMENT PROGRAM with staff of 8 (largest outreach program in the city) targets at-risk populations in Castro, Haight, Western Addition, Mission, Tenderloin and South of Market as well as youth city-wide. Contacts range from condom/brochure/bleach distribution to individual and group prevention education, linkage to social and health services, to ongoing case-management in street setting (a model still a work-in-progress). In-services, referral and consultation to other providers. Variety of print media aimed at crossover of substance abuse and HIV as well as agency outreach at ethnic/local street fairs.

Funding Sources: CSAS, CDC, CARE, AIDS Office.
Contact: Stephen Manning, PhD., Executive Director (861-1928)

HIV Recovery Program Client Flow Chart



HIV Health Service Planning Council
Service Area Providers

Agency/Individual: Walden House, Inc./Jeff Presement, Ph.D.

Service Site: 815 Buena Vista West, 890 Hayes St.,1840 Van Ness

Target Population: HIV/AIDS infected substance abusers as well as clients in need of social model detoxification and safe housing.

Client Demographics: (Number Served/Percentage of Total)
* Note: These are unduplicated clients served during year 1.

Male 41/95% Female 2/5%

White 27/63% African American 10/23% Latino 4/9%

Native American 0 Asian/Pacific Islander: 2/5%

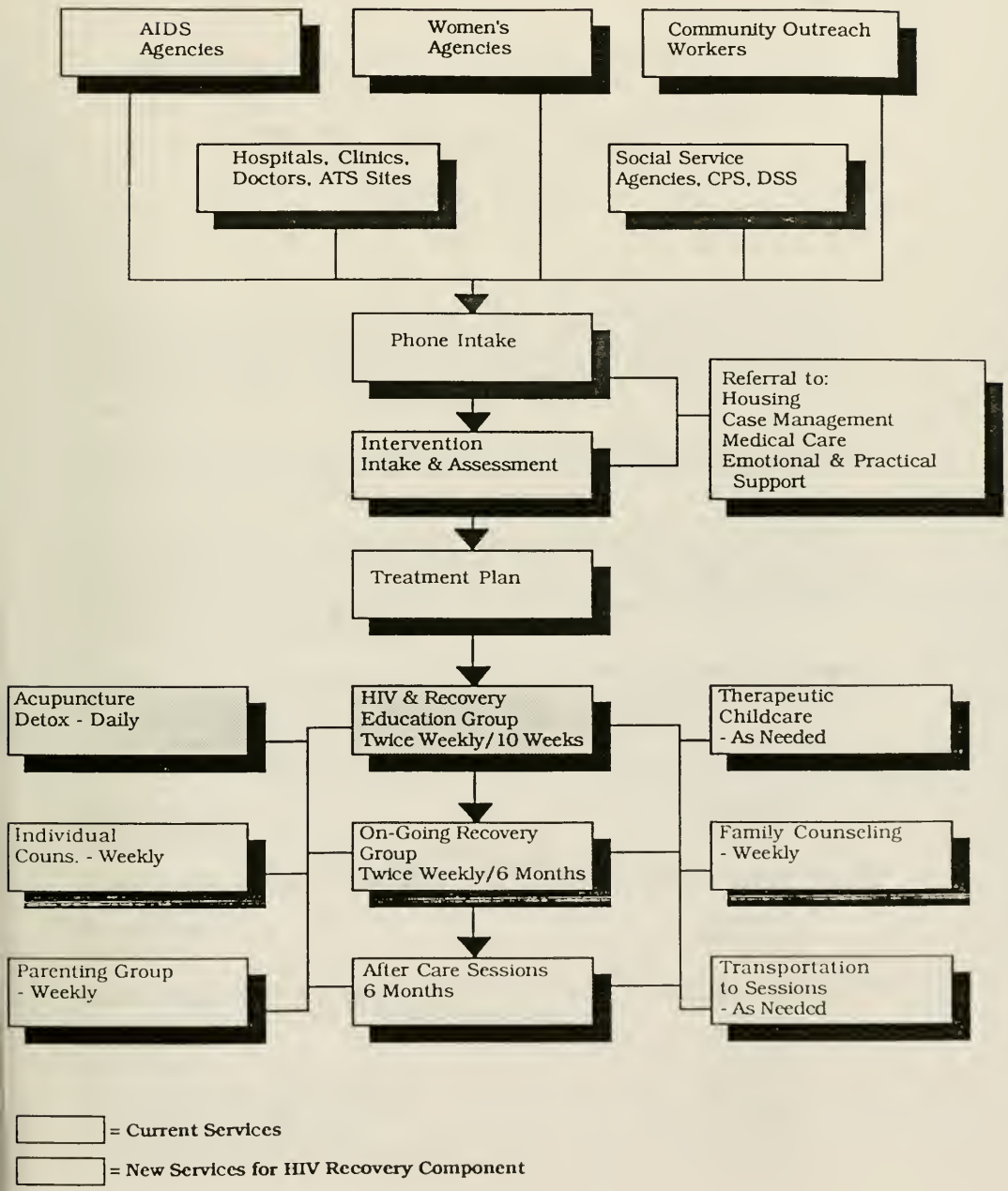
Service Description:

We are providing 30 residential substance abuse beds. Program length varies from 6 months to three years dependent upon individual clients needs. 6 of the 30 beds are for long term congregate living. In addition to substance abuse treatment, clients receive coordination of primary medical care, in-house alternative healing, nutritional counseling, mental health services if needed, individual HIV/AIDS counseling and support groups. In addition under year two CARE funding (numbers not reflected above) we also provide aftercare services to clients that complete the residential phase of treatment and have opened a twelve bed social model detoxification program and safe house. Clients detoxify with use of herbs, acupuncture, and body work by licensed practitioners. They can then choose to enter residential and or day treatment at Walden House or remain in safe housing until an appropriate placement can be found. During this time clients who usually have not received primary heath care for their HIV disease are linked with other CBO's to receive care.

Funding Sources:

Our HIV/AIDS services are funded through CARE FORMULA and CARE SUPPLEMENTAL contracts. Our agency, which provides services to over 400 clients is also funded by contracts with the San Francisco Department of Public Health Community Substance Abuse Services, as well as other State and Federal Sources.

HIV Recovery Program Client Flow Chart



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THE MAYOR'S HIV HEALTH SERVICES PLANNING COUNCIL
COMMUNITY MEETING

COMMUNITY SUBSTANCE ABUSE SERVICES
MEMO OF UNDERSTANDING

AUGUST 24, 1992

There is a strong association,we believe, between all chemical abuse and HIV infection. Although the connection between injection drug use and HIV infection and transmission has been well established, abusing alcohol and other non-injected drugs is also related to the spread of HIV disease in at least two ways: 1) substance abuse adversely affects the immune system; and 2) it allows high risk sexual behavior.

In a Study of Health and Risk Practices (SHARP) conducted among a sample of clients served by Community Substance Abuse Services (CSAS) providers, we found that 6.9% of our clients were HIV infected.

Given these connections between substance use and abuse and HIV infection, the Aids Office and CSAS entered into a Memorandum of Understanding (MOU) "to successfully coordinate the agencies and issues involved in substance abuse treatment and clients with HIV disease". CSAS further agreed to manage CARE Substance Abuse Contracts and to assure contract compliance through monitoring and evaluation.

CSAS and the AIDS Office currently have ten contracts with seven agencies to provide services to substance abusers who are HIV infected. These programs are funded under the Ryan White CARE Act and total $2,282, 714. They are as follows:

CARE Formula (Renewals)	**May 1, 1992 to April 30, 1993**
Walden House	$209,000
18th Street Services	$151,724
CARE Supplemental (Renewals)	**July 1, 1992 to June 30, 1993**
Walden House	$223,661
Baker Places	$218,196
CARE Supplemental (New)	**July 1, 1992 to June 30, 1993**
Walden House	$375,000
Baker Places	$461,417
Women's Institute for Mental Health	$198,688
Salvation Army Harbor Light Center	$120,028
Haight Ashbury Free Clinics	$ 75,000
UCSF Substance Abuse Services, SFGH	$250,000

Walden House

Under their two renewal contracts Walden House will serve 42 unduplicated clients who are substance abusing HIV infected men and women in need of residential drug treatment. Walden House offers long term Therapeutic Community Treatment. Clients who are HIV infected receive the same services as other non-HIV infected clients, but special groups, lectures and counseling are offered to them.

Walden House's new contract is for 12 detoxification beds for substance abusing men and women who are HIV infected. The detoxification stay is for 21 days and is Social Model in nature. People needing medical detoxification will be appropriately referred. After detoxification clients may be transferred into other Walden House programs or to other community agencies depending on their need for continuing care.

Baker Places

Baker Places has two contracts with CSAS to serve HIV infected substance abusers. The first contract serves 50 ethnic and racial minority men and women in need of residential drug and alcohol abuse treatment without regard to sexual orientation. The length of stay is from 90 to 180 days.

Their new contract will serve 42 unduplicated clients in a 12 bed facility. These clients will include the homeless, lesbians, gay men and bisexuals. They will also serve dually diagnosed clients who have mental illness problems as well as a history of substance abuse. Services include group and individual counseling and case management. A satellite co-operative housing unit will be available for clients after they complete the residential treatment phase. This housing will provide the minimum level of structure and supervision necessary for clients to maintain their sobriety and stability in the community.

18th Street Services

Under this contract 18th Street Services has hired three new counselors to expand its existing outpatient substance abuse counseling program. These counselors will provide both group and individual substance abuse counseling to three distinct underserved populations who are living with HIV infection: Latino gay and bisexual men; younger gay and bisexual men, ages 18 to 27; and gay and bisexual men in recovery from alcoholism and drug addiction who need aftercare services or advanced counseling services in order to maintain their sobriety in the face of stresses brought on by their HIV disease.

Women's Institute for Mental Health

This is a new contract for the Women's Institute for Mental Health. The core of the program is outpatient detoxification, treatment and aftercare recovery groups designed specifically to meet the needs of HIV infected women. Women will start the program with a six to ten week detoxification and education group to stabilize their abstinence and decrease relapse episodes. Once stabilized they will enter a six month on-going recovery group for HIV infected women. This group emphasizes relapse prevention, health maintenance including nutrition, and coping with issues of grief and loss. Upon completion of the recovery group these women will participate in an aftercare group for an additional six months. Therapeutic child care is also provided.

Women's Institute for Mental Health (continued)

A daily acupuncture clinic will be available to relieve the severity of withdrawal symptoms and to enhance the functioning of the immune system.

Salvation Army Harbor Light Center

These services are for homeless alcoholic and drug addicted men who are HIV infected. Salvation Army Harbor Light Center will set aside ten of the 48 beds in their Men's Recovery Home for men with HIV disease. An HIV Coordinator provides outreach to homeless men on the street and follows them through residential social model detoxification. Referral will then be made to the Recovery Home. The expected length of stay in the Recovery Home is 90 days. Aftercare is provided to ensure that the individual is receiving proper care for his HIV disease and maintaining a solid support program for his addiction.

Haight Ashbury Free Clinics

The Haight Ashbury Free Clinics will hire a psychiatrist who will treat psychiatric illnesses in HIV infected substance abusers and thereby ameliorate the catastrophic effect that it can have, if untreated, on the course of HIV infection. This psychiatrist will be stationed in their Drug Detoxification, Rehabilitation and Aftercare Program.

UCSF Substance Abuse Services SFGH

Under this contract UCSF Substance Abuse Services at SFGH will offer three distinct services: 1) a six month outpatient methadone detoxification for HIV+ heroin users;
2) a four month cocaine and amphetamine detoxification for HIV+ patients; and
3) primary medical, psychiatric and social services to these clients treated in the new detoxification programs. A total of 67 unduplicated clients will be treated in the first year.

Other MOU Activities

In addition to negotiating, monitoring and evaluating the above contracts, CSAS also is involved with a variety of other tasks under the terms of our Memo Of Understanding with the AIDS Office. We have offered a number of training events to our providers on issues of working with HIV infected substance abusers; we have surveyed all CSAS providers on their knowledge of and need for HIV training; we are establishing a computer based system to determine immediate availability of treatment slots; and we are acting as an ombudsperson for clients who are HIV infected and who need special help in getting into appropriate treatment facilities.

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FRANK M. JORDAN

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August 24, 1992

TO: Honorable Kevin Shelley, President
and Members
San Francisco Board of Supervisors

THROUGH: Mayor Frank Jordan

FROM: Margaret Kisliuk
Deputy Chief of Staff

RE: Update on the State Budget

This is to provide you with an update on the State budget. It builds upon the weekly reports that have been provided to the Finance Committee by Chief Administrative Officer Rudy Nothenberg and myself. Please feel free to contact me if you need further information.

Status of Legislative Deliberations

Both the Senate and Assembly met until after 11:00 p.m. last night. The Assembly did not take up any budget-related items. The Senate passed, and the Governor quickly vetoed, the Assembly's education budget bill. Both houses are scheduled to meet this afternoon, and probably through the weekend.

While predictions vary, it appears that the State budget may not be adopted until the last day of the session; August 31. Some even predict that it will not be adopted by then.

Fiscal Implications for San Francisco

There are three budget proposals being actively discussed. At this point, they have not been reconciled. We have heard some rumors of behind-the-scenes agreements on some of these items, but these are unsubstantiated.

The most recent information presents the following picture for San Francisco:

($ millions)

	Assembly	Senate	Governor
Repeal of Prop. 13 "bailout"	$ 43	$ 50-55	$ 45
Port net profits	4	?	0
Redevelopment property tax monies	0 at this point	1 to 1.5	?
MUNI transit development tax	0 at this point	0	0
Health and Welfare and miscellaneous	5-10	10 or more	10-15
Property tax delinquencies	0	0	2.2
TOTAL ESTIMATED S.F. IMPACT	52-57	61 to 66.5	57.5 to 62.5

Explanation of items:

Prop. 13 bailout: The State proposes to take back part of the monies that were transferred to cities, counties and special districts after the adoption of Prop. 13. The monies were allocated according to the jurisdiction's property tax rate, as well as the level of health and social services that the jurisdiction provided. San Francisco had relatively higher levels of property taxes, as well as relatively higher levels of health and welfare services. Thus, we received a relatively greater proportion of the original bailout monies and are now receiving a proportionate amount of the bailout cut. Note that for the most part we are considered a county, rather than a city, in this calculation.

The amount calculated for the bailout cut in the Assembly version of the budget includes a 15% "discount" for cities that were declared federal disaster areas since October 1989. That is, the Assembly's bailout cut would have been over $50 million, but for this 15% reduction.

Port net profits: There is a proposal to take up to $4 million in net profits from the various ports around the State. While the original version of this legislation would cost our Port $4 million, the latest version has this amount of money going to the City rather than the State General Fund. Thus, at this point, this does not appear to be our highest concern. Port staff and their representatives in Sacramento continue to monitor this item closely.

Redevelopment agency: Over the past month, there have been a variety of confusing formulas proposed that would allow the State to shift property tax monies from cities to the school districts, based upon the amount of property tax allocated to the local redevelopment agency that can be attributed to schools. That is, when the Redevelopment Agency was created, it received property tax monies that could be attributed to the schools, as well as property tax monies that could be attributed to the city or the county. Most of these formulas affect us only minimally, because of the unusual status of our Redevelopment Agency and our status as a combined city and county.

MUNI transit development assessment fee: Local transit districts receive 1/4 cent from the State sales tax. For the MUNI, this is $4.6 million that is used for operations. At one point, there was an Assembly proposal to take these monies away from local transit districts and appropriate it to the State General Fund. We are informed that this is not an active proposal at this point, but continue to monitor the situation.

Health and welfare and miscellaneous: It has been extremely difficult to accurately monitor the proposed cuts in health and welfare services. For the most part, the proposals are not written and my assessment is based upon a variety of conversations with Legislative staff and advocates for health and welfare groups.

I understand that the Senate version of the budget will include an $85 to $90 million cut in State monies for benefits that are "optional" under Medi-Cal. That is, the federal Medicaid program gives states the option to provide certain benefits, that the State thus has the option to eliminate in this budget year. The fiscal effect on San Francisco from the elimination of optional Medi-Cal benefits depends upon which benefits are chosen for elimination. They could range from items such as drugs and pharmaceuticals or dental care to chiropracty or nonemergency medical transportation.

In addition, all three versions of the budget include cuts in "Prop 99 Tobacco Tax" monies for health services; and elimination of funding for a long list of State mandates that affect many City departments including the Health Department, Library, Registrar of Voters, and others.

Property tax delinquencies: While the language is not yet

available, it appears that the Governor's budget will take the monies currently collected by counties as penalties for property tax delinquencies, and appropriate these monies to the schools. This represents a $2.2 million annual loss in San Francisco.

Possible Revenue Proposals

Sales Tax: Most California counties currently have the authority to raise their sales tax by 1/2 cent, by a majority vote of the Board of Supervisors. San Francisco currently does not have this option. Pending legislation would remove the special restrictions on San Francisco, allowing a 1/4 cent increase in the sales tax, to 8.75%. This would raise about $30 million in FY 1992/93.

As you know, there are significant policy concerns associated with raising the sales tax. In addition, there is the concern that our sales tax be consistent with those imposed by surrounding counties. At this point, I have only heard of one Bay Area County that may raise its sales tax in response to the State budget; Alameda County.

There may also be legal problems associated with the raising of the sales tax by a majority vote of the Board of Supervisors. There are some who argue that the Board cannot impose this tax without a vote of the people. However, I understand that the State Legislative Counsel does not think that this legal theory would prevail, and that the tax can be imposed by a majority vote of the Board of Supervisors.

Bank in lieu tax: Currently, the State collections $100 to $150 million from banks in lieu of their paying locally-imposed taxes, such as the local gross receipts or utility users tax. There is a proposal to lift this State restriction, so that local governments can tax the banks in the same way as other businesses are taxes. I understand that this could generate between $10 and $20 million in San Francisco, should the Board choose to tax banks in the same way as other businesses are taxed.

Health and Welfare Mandates

In addition to the fiscal effects, there has been a lot of discussion and activity surrounding the State's mandate that counties provide health and welfare services to the poor. These are embodied in Welfare and Institutions Code Section 17000 and elsewhere. The Governor and various members of the Legislature have proposed eliminating or significantly reducing these mandates, arguing that this will alleviate the burden caused by the severe reduction in State property tax monies allocated to counties.

One of the primary players on this issue is the California State Association of Counties (CSAC). As you know, members of the San Francisco Board of Supervisors, including Supervisors

Shelley, Kennedy, Migden and Gonzalez, have actively worked against a CSAC position for repeal or significant weakening of the health and welfare mandates. Due in large part to these efforts the current CSAC position, particularly in regards to General Assistance, does not call for a major change in the mandates. In fact, this has been an issue between CSAC and the Governor; the Governor has criticized CSAC's moderate position on G.A.

Last week, however, both the Assembly and the Senate adopted legislation that does weaken these mandates. The legislation pending before the Governor allows for reductions in General Assistance levels to be consistent with AFDC/SSI cuts; other changes in General Assistance to allow counties to reduce grants to individuals who share housing and to reduce grants for General Assistance recipients who do not comply with program restrictions. There were no changes to the health sections of Welfare and Institutions Code 17000, but there were major changes in the requirement for Bailenson hearings when health services are cut; for the level of effort counties must maintain to receive State health program monies; and for data reporting to the State.

Members of the Legislature continue to push for greater restrictions on health and welfare programs, but these efforts are not expected to be successful. They range from proposals that would allow counties to eliminate general assistance entirely, to proposals to repeal Section 17000 health care.

Finally, it appears that both houses of the Legislature will agree to a 5.8% cut in AFDC and SSI benefits. This is greater than the 4.5% cut originally proposed by the Legislature, but far less than the 10% to 25% cut proposed by the Governor and embodied in Proposition 165 for the November ballot (the Governor's welfare initiative.)

We continue to monitor the health and welfare situation as closely as we can.

Summary

The State budget situation continues to be very fluid. I have been working closely with staff from the Controller's Office, Department of Social Services, Health Department, City Attorney and others to monitor the State budget, and to influence it in San Francisco's favor where possible. We will try to keep the Board as fully informed as possible. Please feel free to call me if you have questions.

cc Chief Administrative Officer Rudy Nothenberg
Controller Ed Harrington
Jim Lazarus, Mayor's [redacted] Chief of Staff
Department Heads

City and County of San Francisco

Department of Public Health
Division of Mental Health,
Substance Abuse and Forensic Services
Community Substance Abuse Services

August 21, 1992

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To: Jeff Jue MSW

From: Wayne Clark Ph. D

Re: **MediCAL Methadone update**

OUTPATIENT METHADONE MAINTENANCE-OPTIONAL BENEFIT, DADP is recommending that Outpatient Methadone Maintenance be eliminated as an optional benefit under Drug Medi-Cal. There are 19 counties that are currently under this program and they will lose approximately $4.4 million of federal matching funds(total $8.8 million in programs). The department has submitted amendments and corresponding budget reduction requests to the legislature. The statutory elimination of the benefit is stated to be included in one of the budget trailer bills, SB 919. To date, several amendments have appeared. Preliiminary language would eliminate the benefit.

The proposal is not receiving an enthusiastic response in the legislature. Staff to the budget writing committee is questioning whether or not the elimination of the benefit is a budget issue.

The proposal, if approved, would impact over 2800 methadone slots statewide and effect approximately 400 slots in San Francisco. The amount of funding San Francisco would lose is:

	Total	Fed Share
BAART, FACET	$243,323	$121,662
BAART, Geary	287,849	143,925
BAART, Twonsend	516,167	258,054
BVHP	240,000	120,000
SFGH, Ward 93	300,000	150,000
Westside	294,434	147,217
	$1,878,773	$939.387

CSAS is monitoring the issue, but things are moving in strange ways in Sacramento. The elimination of methadone slots would have an especially adverse impact on HIV infected individuals and pregnant women.

ESTABLISHMENT OF A STATE NARCOTIC ABUSE TREATMENT PROGRAM

Proposal

Eliminate heroin detoxification as a Medi-Cal optional benefit and establish a "State-only" narcotic abuse treatment program funded with $5.3 million from the General Fund for fiscal year 1992-93. The narcotic abuse treatment program would include outpatient heroin detoxification and outpatient methadone maintenance services.

Background

Heroin detoxification services are provided to Medi-Cal beneficiaries through California's fee-for-service Medi-Cal program. Heroin detoxification is a 21-day program during which decreasing amounts of methadone are administered to a client to wean heroin and other opiate addicts from the narcotic.

Federal Medicaid specifications do not require that heroin detoxification be provided as part of a state's Medicaid program; rather, heroin detoxification is an optional state benefit. Approximately $1.2 million from the General Fund is appropriated to match $1.2 million of federal funds to provide heroin detoxification services. The Administration has proposed the elimination of heroin detoxification as an optional Medi-Cal benefit. Assuming implementation on October 1, 1992, this action would result in an estimated $0.9 million General Fund savings in FY 1992-93.

Outpatient methadone maintenance services are provided in 18 participating counties through the Drug/Medi-Cal program operated by the State Department of Alcohol and Drug Programs (DADP). The purpose of outpatient methadone maintenance is to stabilize the narcotic addict by alleviating the symptoms of withdrawal through regular doses of methadone.

Under federal provisions, outpatient methadone maintenance is provided as an offshoot of heroin detoxification services; however, California's outpatient methadone maintenance program was not established as part of the fee-for-service Medi-Cal program administered by the Department of Health Services (DHS). Rather, in California, outpatient methadone maintenance is offered as part of the Drug/Medi-Cal program through an interagency agreement between DADP and DHS. As part of this program, DADP subvenes $4.4 million in General Fund dollars to the counties to match up to $4.4 million in federal Medicaid funds. The Administration's proposal to eliminate heroin detoxification as an optional Medi-Cal benefit will result in the loss of federal Medicaid dollars for outpatient methadone maintenance offered through the DADP Drug/Medi-Cal program.

Litigation

Two suits have been filed in federal court (Merritt et al. v. Coye, DHS, DADP, Department of Finance, County of Alameda and Sobky et al. v. Gould, Mecca, Coye, et al.) that relate to the provision of outpatient

methadone maintenance services in California. The Merrill case is a class action complaint on behalf of persons in need of outpatient methadone maintenance. The Sobky case is a class action complaint on behalf of methadone maintenance providers as well as persons in need of outpatient methadone maintenance.

Both cases allege that the California's outpatient methadone maintenance program denies persons like the plaintiffs medically necessary methadone maintenance services. Plaintiffs further allege that methadone maintenance services are not available statewide; that eligible recipients have been denied their free choice of outpatient methadone maintenance providers in violation of federal law; and that DHS has unlawfully delegated its Medicaid single state agency authority to DADP and county drug program administrators.

The potential additional total cost of these outpatient methadone maintenance suits is estimated to be between $20 million and $30 million ($10 million to $15 million General Fund).

New Program

The Administration is proposing the establishment of a narcotic abuse treatment program funded exclusively with State general funds. As proposed, the narcotic abuse treatment program would utilize Medi-Cal eligibility criteria. Additionally, DADP would be authorized to adopt additional eligibility criteria and to establish priority populations to receive these services.

For fiscal year 1992-93, this program is proposed to be funded with the $4.4 million General Fund (currently subvened by DADP for outpatient methadone maintenance) as well as with the $0.9 million General Fund savings associated with the elimination of heroin detoxification as an optional fee-for-service Medi-Cal benefit. These funds would be allocated by DADP to counties through the existing system to assure that outpatient heroin detoxification and outpatient methadone maintenance services are provided to the highest priority population. Additionally, DADP would be authorized to contract with providers should counties opt out of contracting for these services. It is estimated that approximately one half as many clients would have access to these services since federal Medicaid dollars would no longer be available.

Conclusion

This proposal would render moot the arguments advanced by the pending litigation and avoid any potential future fiscal impact of these suits -- while preserving a core State program serving a critical population. Importantly, this program could be built upon and expanded in the future to address critical public health needs.

8/20/92

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But House members complained that spending was severely limited by budget rules and entitlement programs, which ate up 74 percent of the House's Labor, HHS and Education spending this year.

Appropriations committee chairman Rep. William Natcher (D-Ky.) refused to allow spending obligations to be delayed until the next fiscal year, a budget trick used in the past by Congress to boost current-year spending, and recommended by the administration as part of its spending plan.

Meanwhile, the Senate has even less discretionary spending authority than the House did, which limits the hopes of the addiction field about the Senate performing its traditional "white knight" role of restoring House drug and alcohol spending cuts. "I'm not very optimistic" about substantial increases, said Canova.

Central to the problem, she notes, is that the Labor/HHS/Education bill "funds all the good programs," meaning domestic assistance, so choosing one over another is especially difficult.

Canova also worried that once block grant spending is split between addictions and mental health (according to the new Substance Abuse and Mental Health Services Administration law), drug and alcohol treatment and prevention could suffer further cuts. On the other hand, she held out hope that treatment programs will be able to access increased funds for preventing and treating tuberculosis — a major problem among drug abusers.

ADAW Special Report

Can Clinton Be Counted Upon to Make Addictions a Priority?

By now, most people have heard at least something about Democratic presidential candidate Bill Clinton's background. Remarkably, two of the major events of Clinton's life have been related to alcohol and drug abuse: his step-father's alcoholism and its effect on Clinton's mother and the whole family; and the drug addiction and subsequent arrest on drug charges of Clinton's brother, Roger.

In a recent letter to a mental health group, Clinton listed national health care, children, alcohol and drug abuse, and homelessness as his top priority areas in mental health policy. But will personal involvement with these issues, coupled with a campaign pledge to provide addiction treatment on demand (see *ADAW*, March 18), really translate into a comprehensive drug strategy under a Clinton Administration? And does the candidate's record as Governor of Arkansas back up his claim of being a treatment and prevention advocate?

Judging by the consensus of comments by treatment providers in Clinton's home state of Arkansas interviewed by *ADAW*, the answer appears to be yes. Though support was not unanimous, Clinton got kudos both from treatment providers unsure of who they would vote for and from avowed Clinton supporters.

Personal experiences and involvement

"He's had a hard time personally with [his brother,] Roger," said Scott Gordon, L.C.S.W., the associate administrator of Arkansas Children's Hospital in Little Rock. "He's experienced the pain firsthand. I think there will be a real sensitivity to what people experience and go through."

Said the program manager of a hospital-based treatment facility, who requested anonymity because he is an acquaintance of Clinton family: "Clinton is more enlightened about the notion of chemical dependency than most people in the public policy making business. He has always been a strong advocate of education, and as a corollary to that he is always a strong advocate of health and human services.

As a treatment provider, he called Clinton "an excellent candidate for political office from perspective."

"I think [Clinton's background] offered him a real opportunity to become aware of the problem," said the program manager. "He views it as a disease process rather than a criminal problem that needs to be stamped out."

However, one Clinton critic, Rick Newton, director of the recovery program at the Baptist Rehabilitation Institute, took the opposite tack. "I'm surprised that with chemical dependency touching his family as it has [that] he has not [shown] enough leadership ... I would like a more vocal advocate for treatment."

Most of those we spoke with gave Clinton high marks for personal involvement in the issue — regularly playing a major role at the annual MidSouth Summer School on Addictions, for example — as well as having a cooperative and helpful state alcohol and drug abuse office.

In particular, those *ADAW* spoke with said Clinton has encouraged cooperation between state departments to provide comprehensive services, emphasized the im-

portance of early intervention and prevention and family-centered treatment, and strengthened the state's community-based provider system.

A sense of cooperation

One of the most important aspects of Clinton's style of mental health management is his insistence on a high level of communication between related departments — such as education, juvenile justice, and mental health — on policies and programs. Gordon said that Clinton both encourages and facilitates such a "cross discipline problem solving approach," and the results of this partnership have been so effective in Arkansas that he believes that it will be part of a Clinton national health care plan.

Highlighting the cooperation encouraged by Clinton, Gordon pointed out that even literacy programs in the state do drug referrals; literacy and other workers who go into homes are trained to identify problems and make referrals when needed. "Even when you are talking about family literacy or early childhood development as the primary thrust of what you're doing, you still don't ignore the fact that when you get into the home you're going to see other things ...," he noted.

Gordon called a theme of cooperation and working together "one of the hallmarks of the [Clinton] administration."

Gail Harber, M.S.M., NCAC II, coordinator of addiction studies at the University of Arkansas medical studies department, also praised Clinton for "being really sensitive" to addictions. And she had kind words for the state's strong interagency substance abuse group, which she said was started at the request of the governor's office.

Harber, who is the president of the local chapter of the National Association of Alcohol and Drug Abuse Counselors (NAADAC), added that her contacts inside the state drug agency say they are genuinely pleased with the support they get from Clinton.

Services for women; prevention for children

Early identification and prevention is the focus the Clinton administration "has consistently brought to bear on all services," according to Kelly Kelleher, M.D., M.P.H., assistant professor of pediatrics and psychiatry at Children's Hospital. "I think their main focus ... has been prevention ... They want to see high risk families and children started in services early," he said, mentioning early intervention in schools, as well as identifying and aiding children of alcoholics, as areas that Clinton has prioritized.

"The things that are lacking will get more attention because these are the things Clinton has been advocating for ... services for women, and teenage and pregnant girls who have substance abuse (problems)," Kelleher said. Adds colleague Gordon: "This is a hot topic right now," with a number of grants and projects being proposed by the state.

Another provider said that Clinton-backed boot camps for juvenile drug offenders have produced tangible benefits. Clinton has previously said that he would like to see this program expanded on a national level.

Both Kelleher and Robert Marsh, administrative director of the Child Health and Family Life Institute (CHFLI) at ACH, repeatedly stressed throughout the interview that all of the programs developed and operated under Governor Clinton have revolved around a "family focus."

Cocaine gets the major national focus, adds Kelleher, but the biggest drug problem facing the nation is alcoholism, especially in rural areas. "The administration here [has] been very supportive of our efforts to set up fetal alcohol prevention projects and do high school demonstration projects," he said.

Harber said that while programs in Arkansas "obviously have not" received as much funding as they need, she feels they have gotten an "equitable share" of available state resources. She credited the administration for funding "a lot of creative, innovative programs," including substance abuse training for resident physicians and perinatal substance abuse programs.

Harber said she was unsure if she would vote for Clinton, but gave him credit for evolving on at least one topic. She said the governor expressed interest in punishing perinatal substance abuse a few years back, but has since turned from a punitive approach to employing addiction treatment to address the problem.

Not everyone was impressed with Clinton's role in drug and alcohol issues, though. "I'd be hard pressed to say there's any issue he's provided leadership on," said Newton. "I haven't gotten the impression that he's taken a very active stand" on addictions, he added.

Small but steady funding increases

Operating in a state that requires a balanced budget, Clinton has presided over a series of small but steady increases in state addiction spending. According to state budget documents obtained by *ADAW*, state general revenue outpatient treatment spending rose from $107,179 in 1984/1985 to $291,701 in 1990/1991. General revenues inpatient treatment from $428,699 in 1984/1985 to

$502,668 in 1990/1991.

General revenues — state money — also fund the only detoxification center in the state. Funding for the Benton Detoxification Center has risen from $1.298 million in 1984/1985 to $1.669 million in 1990/1991.

Following a national trend, Arkansas' share of the total addiction budget has varied but generally increased versus the federal contribution over the past decade. From a 74 percent federal / 26 percent state split in 1984-85, Arkansas' share of the budget increased to 37 percent in 1990/1991, with the federal government contributing 63 percent.

The ratio of money spent on treatment versus prevention also has varied, though the state has consistently spent at least twice as much on the former. In 1990/1991, 78 percent of the budget went to treatment, versus 13 percent for prevention.

If budget reductions are made, says Gordon, "the thrust [of the Clinton administration] has always been to preserve programming at the local level to the furthest extent possible." Reductions usually are taken in administrative costs, he notes, by reducing hiring and operational expenses.

If budget necessities do force service cuts, Marsh said Clinton's tendency has been to reduce the levels of a few services rather than drop one entirely. "One of the keys," he said, "is to take one's blinders off — which we've been encouraged to do in this state — and provide a combination of services to a combination of clients, because the management of one teaches you about the management of the other."

— Keith M. Rosen and Robert Curley

Clinton, Gore in Therapy: Sensitivity, Not Liability

For this year's Democratic presidential ticket, the mental health issue runs from the political to the personal level. Both Bill Clinton and his running mate, Al Gore, have sought psychological counseling: Gore in the wake of his son's near fatal accident, and Clinton at the request of his brother's drug counselor. The questions remain, though, as to whether these experiences will make the ticket more sensitive to chemical dependency and mental health concerns, and whether it will become a liability in November.

"I think it's a very healthy thing," says Phyllis Greenberger, a psychiatric social worker and a member of Clinton's Health Advisory Committee. "There are situations where people have difficulties. It takes a strong person to admit they need help."

"It's a very private thing; I don't think it has anything to do with politics," says Max Parker, Clinton's deputy press secretary.

Gore has been candid, albeit not overt, about his counseling sessions; indeed, the campaign uses the incident in the service of "family values."

As for questions about the emotional aftermath and the counseling both he and his wife, Tipper, sought, the candidate is hesitant and refuses specifics. But he has said, "We grew tremendously by becoming aware of how we were dealing with it and how we were relating to one another in the midst of it."

As Governor of Arkansas, Clinton ordered the arrest of his younger brother, Roger, for drug abuse in 1984. The younger Clinton, realizing he was "very sick," sought the help of a family therapist, who suggested that the elder Clinton and his mother join in the sessions. Clinton friends and advisors have said that these sessions helped the governor understand "why he is the way he is."

The Democratic campaign contends that the candidates' involvement in therapy will have no political cost.

"I strongly recommend to any family undergoing an experience remotely similar to what we went through — not to be afraid to do this," Gore said. However, "this" has already earned a few Republican jabs. *The New York Times* quoted a Bush spokesperson as declaring: "Real men don't lie on couches."

> *"Real men don't lie on couches."*
>
> A Bush spokesperson

The American Psychological Association (APA) sharply criticized the Bush caveat. "For a president who espouses family values, it's pathetic," says Dr. Bryant Welch, the APA's executive director for professional practice.

As for public opinion, Greenberger says voters more likely will sympathize with Clinton and Gore rather than castigate them.

— Melissa DeMeo

City and County of San Francisco

Department of Public Health
Division of Mental Health,
Substance Abuse and Forensic Services
Community Substance Abuse Services

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Date: August 24, 1992

To: Mayor's HIV Health Services Advisory Committee

From: Yvonne Frazier, Associate Director
Grants and AIDS Activities

Re: Summary of Non-CARE funded
HIV and Substance Abuse Services

In addition to the CARE funded HIV and Substance Abuse Services, it is important to note that many services are provided by Community Substance Abuse contractors that are AIDS services utilizing other funding. Please review the attached chart for the number of clients enrolled in substance abuse treatment programs, and the summary of programs providing HIV and Substance Abuse Services with non-CARE funding.

Other AIDS specific funding include a grant from the Centers for Disease Control (Counseling and Testing Programs in selected drug abuse clinics), and a TB/HIV Grant (CDC). The attachments regarding programs descriptions are approximately eight months old so the actual amounts for these programs are approximates. (CDC counseling/testing grant is approximately $880,000 and the TB/HIV grant is approximately $138,266).

CSAS receives $3,264,743 to serve Injection Drug Users from the Department of Alcohol and Drug Programs. (HIV Positive or extremely high risk clients).

Non AIDS specific funding for CSAS contractors include Federal Block Grant, City Federal Block, State Federal Block, Waiting List Reduction Grant Continuation Funds, Federal Medi-Cal Funding, State General Funds, City General Funds, Alcohol IRCA, Drug MIA, Drug Federal, Waiting Period Reduction Grant (Sunset last month), City General, State General, Perinatal, Federal Block Perinatal, Save Our Sisters Grant, Bay Area Services Network, Highrisk Youth/Drug Free Schools, School Based Prevention, Alcohol Vocational Rehab, Alcohol Statham, Women's Set Aside DADP, Critical Populations Grant, HALF Grant, Federal CYAP, Client Fees and Other Revenues. Approximately 15% of 26M is estimated to be utilized for clients with HIV (or $3,900,000). This includes a number of programs that provide extensive HIV Services such as 18th Street Service, Operation Concern, HAFMC, Baker Places, and SFGH. It also includes other drug abuse clinics that see clients with HIV as part of their general population.

SUMMARY OF CSAS CLIENT DEMOGRAPHICS
SAN FRANCISCO

FY 90/91 DRUG PROGRAMS NUMBER	FY 90/91 DRUG PROGRAMS PERCENT	CHARACTERISTIC	FY 89/90 ALCOHOL PROGRAMS NUMBER	FY 89/90 ALCOHOL PROGRAMS PERCENT
9,956	100%	**Total Clients**	11,888	100%
		GENDER		
6,285	63%	Male	9,332	78%
3,671	37%	Female	2,556	22%
9,956	100%		11,888	100%
		ETHNICITY		
4,696	47%	White	5,563	47%
3,510	35%	Black	4,496	38%
1,192	12%	Latino	1,227	10%
454	5%	Asian	153	1%
104	1%	Native American	285	3%
9,956	100%	Other	164	1%
			11,888	100%
		AGE		
138	1%	Under 18	141	1%
1,332	13%	18 - 25	1,422	12%
3,627	37%	26 - 35	4,476	38%
3,696	37%	36 - 45	3,636	30%
1,094	11%	46 - 64	1,992	17%
69	1%	Over 64	221	2%
9,956	100%		11,888	100%
		PRIMARY PROBLEM AT ADMISSION		
6,105	61%	Heroin / Alcohol	6,674	56%
457	5%	Amphetamines / Co-Alcohol	270	2%
2,133	21%	Cocaine / Alc. & Drugs	4,776	40%
112	1%	PCP / Other	168	2%
1,149	12%	Other	11,888	100%
9,956	100%			
		SERVICE MODALITY		
4,507	45%	Detoxification	3,351	28%
480	5%	Residential	1,396	12%
2,878	29%	Outpatient Drug Free	5,653	48%
2,091	21%	Methadone Maintenance	N/A	N/A
N/A	N/A	Information/Referral	1,488	12%
9,956	100%		11,888	100%

Source: CSAS, Epidemiology Unit, Annual Report, Unduplicated by Program, FY 90/91

SIX-MONTH SUMMARY OF CSAS CLIENT EPISODES
SAN FRANCISCO, JULY 1, 1991 - DECEMBER 31, 1991

Characteristic	Primary Drug Problem		Primary Alcohol Problem		All Problems	
	Number	Percent	Number	Percent	Number	Percent
Gender						
Male	5,002	64%	3,403	80%	8,405	69%
Female	2,845	36%	873	20%	3,718	31%
Total	**7,847**	**100%**	**4,276**	**100%**	**12,123**	**100%**
Ethnicity						
White	4,078	52%	1,891	44%	5,969	49%
Black	2,673	34%	1,856	44%	4,529	37%
Latino	652	8%	389	9%	1,041	9%
Asian	365	5%	59	1%	424	4%
Native American	79	1%	81	2%	160	1%
Total	**7,847**	**100%**	**4,276**	**100%**	**12,123**	**100%**
Age						
Under 18	105	1%	32	1%	137	1%
18 - 25	887	11%	383	9%	1,270	10%
26 - 35	2,798	36%	1,515	35%	4,313	36%
36 - 45	3,029	39%	1,451	34%	4,480	37%
46 - 64	963	12%	818	19%	1,781	15%
Over 64	65	1%	77	2%	142	1%
Total	**7,847**	**100%**	**4,276**	**100%**	**12,123**	**100%**
Modality						
Detoxification	3,551	45%	2,239	52%	5,790	48%
Residential	644	8%	529	13%	1,173	10%
Outpatient Drug Free	1,702	22%	1,284	30%	2,986	25%
Meth. Maintenance	1,884	24%	0	0%	1,884	15%
Prevention	66	1	224	5%	290	2%
Total	**7,847**	**100%**	**4,276**	**100%**	**12,123**	**100%**

Source: CSAS, Epidemiology Unit, Canned SPSS Reports, Duplicated Client Episodes, 5/92.

Source of Funds: Centers for Disease Control (AIDS Office/CSAS)

1. Westside Methadone Treatment Program, 2. Westside Inner City Outpatient Program, 3. Haight Ashbury Free Medical Clinic, 4. Bay View Hunters Point Foundation, and 5. 18th Street Services and 6. The AIDS Health Project. ($556,561)

1. Name of Program: Westside Methadone Treatment Program

What services are provided/to whom: This program offers outpatient methadone treatment and 21 day methadone detoxification for persons addicted to opiates. HIV onsite counseling/testing is provided with pre and post test counseling. A range of HIV risk reduction counseling and risk assessment is provided to all clients. All services are provided to sexual partners of clients admitted into treatment.

Address: 1301 Pierce Street, San Francisco

Waiting List: Yes, the actual waiting period varies from month to month. It is important to call for an appointment.

AIDS Specific Budget: $60,269 12 Months

Approximate Staffing Pattern: 1FTE Counselor .50 Administrative Support

2. Name of Program: Westside Inner City Outpatient Treatment Program

What services are provided/to whom: Westside Inner City Outpatient Services provides outpatient drug free services to adult men and women with a multicultural focus. Onsite HIV counseling and testing is available to clients enrolled in the program as well as extensive HIV risk reduction counseling and information. Pre and Post Test Counseling is provided to all clients electing to receive the HIV test. This program offers individual, group, and family counseling, and provides extensive referrals. All services can be provided to sexual partners.

Address: 1049 Market Street, Mezzanine, San Francisco 94103

AIDS Specific Budget: $60,269 12 months

Approximate Staffing Pattern: 1FTE Counselor .50 Administrative Support

3. Name of Program: Haight Ashbury Free Medical Clinic San Francisco residents with a drug abuse problem may receive a range of service at the HAFMC program such as symptomatic detoxification, outpatient drug free counseling. Clients can receive HIV testing onsite with related pre and post test counseling. All clients enrolled in treatment will receive a range of HIV risk reduction counseling, education and assessment. Extensive referrals are provided to other services and a range of HIV related medical and psy care can be provided directly onsite oat the program. HAFMC does not currently provide HIV counseling/testing to individuals who are not enrolled in their treatment program. All services listed are available to sexual partners of clients enrolled in treatment setting.

Waiting list: Four day "Demonstration" for clients except those who are female, HIV positive, pregnant, or under the age of 18. These individuals get the next available appointment. Typically clients end up waiting a week between scheduling and demonstration.

AIDS Specific Funding: $124,037 12 Months

Staffing Pattern: 2 FTE Counselors, .25 Clerical .25 Administrative Support

3. Name of Program: Bay View Hunter's Point Foundation (AIDS Unit)

4. What services are provided/to Whom: Bay View Hunters Point Foundation provides services to drug dependent individuals in multiple clinics in the Bay View Hunters' Point Area of San Francisco. Services provided include outpatient, methadone maintenance, outpatient methadone detoxification, outpatient drug free. Most of the services are targeted to racial/ethnic minorities with a IDU history, or polydrug dependence problem. The specialized AIDS unit provides HIV risk reduction services, HIV pre/post test counseling, and HIV testing. All services provided by the BVHP) HIV Program area available to sexual partners.

AIDS Specific Funding: $124,037 12 Months

Staffing Pattern: 2FTE Counselors, .25 Clerical .25 Administrative Support

5. Name of Program 18th Street Services

18th Street Services provides outpatient substance abuse counseling to gay and bisexual men. All clients coming for treatment receive an individual assessment of HIV risk and appropriate HIV risk reduction counseling. All clients who have not been tested for HIV or who tested negative more than six months previously are provided information regarding testing, and if they so desire, are referred for testing. Educational materials regarding HIV are provided to all clients, and ongoing HIV risk reduction counseling is provided in an individual and group substance abuse counseling sessions, as appropriate. All 18th Street Services substance abuse counselors are fully trained to provided advanced HIV counseling and information, and all have been trained as antibody test counselors. 18th Street Services has a waiting list for counseling services averaging 20-30 people. Services are provided to sexual partners.

Staffing Pattern: 1FTE Counselor .50 Support/Administration

AIDS Specific Funding: $62,018 12 months

6. Name of Program: Aids Health Project

Description: HIV Pre/Post Test Counseling training Program. Antibody pre and post test counseling trainings, emphasizing strategies for work ing with substance abusers, are offered on a regular basis. training is provided to all CDC funded providers, substance abuse treatment providers, and other interested individuals. Extensive information is provided regarding referrals to STD, TB, partner notification, and early intervention programs. This is a coordinated HIV training program.

AIDS Specific Funding: $125,932 12 Months

Grand Toal CDC Counseling/Testing/Training $556,561

Source of Funds: Centers for Disease Control (TB Clinic/CSAS) HIV/TB GRANT ($78,000)

1. SFGH-SAS (WD 93), 2. BVHP, 3. Westside Methadone Treatment Program.

What services are provided: $26,000 is provided to each of the three listed programs. These funds pay for the salary of a nurse to provide TB identification, treatment to addicts enrolled in the clinics. Targeted are individuals with HIV and TB. Extensive specialized referrals are provided (i.e., to STD clinics).

Total AIDS Specific Funding: $78,000 (12 Months)

Staffing: 3 .50 FTE Nurses

B. Programs providing significant AIDS Specific Services without AIDS Specific Funding

1. **18th Street Services** **$361,977**

   (See Attached Summary. Outpatient Drug Free Services/Outreach and Education for Gay Men)

2. **Operation Concern/Operation Recovery** **$148,884**

   (See Attached Summary. Outpatient Drug Free Services for Gay Men)

   Source of Funding: State General, City General,

3. **Haight Ashbury Free Medical Clinic** **AIDS Component: $112,000 Research HIV $24,000**

4. **Baker Places Acceptance Place** **$220,054**

   (See Attached Summary: Residential Substance Abuse Treatment for Gay Men. More than 90% of the clients are HIV positive).

5. **San Francisco General Hospital (Ward 93) Pace Program.** **$293,151**

   (See Attached Summary. Methadone Treatment for clients with HIV)

Significant AIDS Services (without AIDS Specific Funding) $940,012

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City and County of San Francisco

Department of Public Health

San Francisco General Hospital
Medical Center

July 24, 1992

Dear Dr. Okin,

We are writing to express our concern regarding a patient with a diagnosis of AIDS dementia who was being treated on the Medical Service and was subsequently transferred to Ward 7B and to alert you to a sequence of events with implications for our system of care.

The patient is a 31-year-old male who was admitted to the Medical Service of the hospital on 4/28/92 . Shortly after his admission, it was suspected that the patient was presenting with HIV-related dementia as well as a concurrent organic mania. Both the C/L Service and the AIDS Health Project were contacted by the medical social worker for clinical assessment and treatment recommendations, including possible disposition to St. Mary's AIDS Dementia Unit. A medical work-up was completed to rule out any other possible etiological factors and the patient was referred to St. Mary's. Prior to his hospitalization, the patient had never designated a Durable Power of Attorney for Health Care nor was he competent to do so. The patient was placed on a temporary conservatorship in anticipation of a permanent conservatorship. T-con papers were filed with Superior Court on Friday, May 8th. Mr. Jury suggested that we call him when a definitive date for transfer of the patient developed. (St. Mary's requires a Durable Power of Attorney or conservatorship. Normally, patients referred to St. Mary's from SFGH have DPAs in place but, in some circumstances, LPS conservatorships must be pursued.)

The patient was scheduled to transfer to St. Mary's ADU on Thursday, May 14th. On Wednesday, Patricia Sullivan of the AIDS Health Project, contacted Ted Jury, Clerk of the Superior Court, to inform him of the patient transfer. She was informed that the T-con was "only good" for SFGH and once the patient left the hospital the T-con would expire. She explained to him that that would render the patient ineligible for transfer to St. Mary's but was informed that she should contact Robert Bunker, public defender, who made the final determination. She then spoke to Herb Ochitill, M.D., and he contacted Mr. Jury. Mr. Jury reiterated to Dr. Ochitill what he had said to Patricia Sullivan. Calls were placed to R. Bunker.

On Thursday morning, Mr. Bunker had still not returned the phone call to Ms. Sullivan. She was able to reach him. In his conversation with her, he stated that he was "philosophically opposed to LPS conservatorships for people with AIDS dementia because it was not a treatable condition." When Ms. Sullivan attempted to explain to him the clinical course, prognosis and treatment available to persons with AIDS dementia, he responded by stating that "people with AIDS Dementia should be on probate conservatorships" and that the system should not have to bend to "accommodate these patients" just because there was a gap in services. Ms. Sullivan explained that the patient was at risk of losing his placement at St. Mary's and he would face possible discharge to a homeless hotel. She further explained to

him that the probate conservatorship program, which the DPH AIDS Office had hoped to develop was dependent on General Funds revenue and slated for elimination based on the coming round of budget cuts. Additionally, the community based organization which had been interested in developing the probate program was no longer willing to do so. Mr. Bunker replied that "a community group should get together and write a grant." Given Mr. Bunker's unwillingness to address the specifics of this particular case, Ms. Sullivan concluded that to continue the conversation would be futile. Mr. Bunker ended the call by saying the decision was Mr. Jury's to make.

At this point, Ms. Sullivan contacted Dr. Mark Leary to seek his advice. Dr. Leary placed a call to Mr. Jury who explained that he would make his final decision early that afternoon.

In the interim, Dr. Ochitill also contacted Mr. Bunker. Mr. Bunker reiterated the same points described above. He added that some mental health programs did not follow through with the conservatorship process.

Late afternoon Thursday, Dr. Leary was informed by Mr. Jury that the continuation of the T-con would not be granted. Dr. Leary and Ms. Sullivan discussed transfer of the patient to 7B and, with the assistance of Dr. Ochitill, the patient was transferred to 7B on Friday. (The patient had been medically stable since Wednesday.)

The decision of the court system in this particular case raises serious questions regarding the care and treatment of future AIDS dementia patients at SFGH. As mentioned previously, the number of patients lacking DPA's and requiring conservatorship represents a small percentage. However, the inability to secure conservatorships will thwart us in our efforts to develop clinically appropriate treatment plans for this population. Furthermore, the Public Defenders Office's apparent lack of information regarding AIDS dementia, coupled with their unwillingness to cooperate when suitable treatment is available, means that some patients will not have access to optimal, humane and much needed care. This patient had no clinical needs that required inpatient psychiatric care--moving him represented a holding operation. This sequence, if repeated, threatens to worsen the already difficult problem of appropriate use of the inpatient psychiatric service and patient flow gridlock.

Our patients deserve a direct route to the care providing facilities that are the best available to assist these patients. This case is an example of a trend in the wrong direction.

Sincerely,

Herb Ochitill, M.D.

James Dilley, M.D.

Mark Leary, M.D.

Patricia Sullivan, M.A.

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AIDS HEALTH PROJECT
A project concerned with AIDS Prevention and Health Promotion

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July 22, 1992

Sandra Hernandez, M.D.,
Mr. Reggie Williams
Co-Chairs
Ryan White/Care Planning Council
The AIDS Office
Department of Public Health
City and County of San Francisco
25 Van Ness, Suite 500
San Francisco, California 94102

Dear Dr. Hernandez and Mr. Williams:

I am writing in regard to treatment delivery issues for patients with HIV-related dementia.

I began neuropsychiatric consultation for community and home-based agencies in 1986. It soon became clear that patients with severe HIV-related dementia were seriously disrupting the delivery of services. As the number of patients with HIV-related dementia increased, this problem was presented to the AIDS Office. A special committee was set-up and after three years of meetings, several conclusions were reached. It was agreed that we needed HIV-related dementia facilities for persons with moderate to severe dementia. Legal issues were addressed with input from the LPS Conservator's Office, the Probate Conservator's Office and the office of Judge Isabel Grant.

It was agreed that LPS Conservatorship was inappropriate, since HIV-related dementia has an identifiable etiologic agent. Further examination revealed several other advantages for the probate conservator method. Unfortunately, the Probate Conservator's Office feels they do not have the staff to handle this problem and should deal only with clients over 62 years old.

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884
Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430
Administrative Office Fax (415) 476 7996 • Fiscal Unit Fax (415) 476-3613
Affiliated with the University of California San Francisco

As you know, the Department of Public Health attempted to establish a separate probate program with an existing money management agency. This attempt failed and I have been informed that the funds necessary for this program have been withdrawn.

From a community point of view, I strongly urge that this program be refunded and started as soon as possible. Due to better medical care and increased longevity, more HIV-related dementia cases are being encountered. Many of these cases cannot be managed without a legal control system being in place. This is particularly true when organic mania complicates the clinical picture.

It seems there are only two options. We must either establish a program under the Department of Public Health or approach the Mayor's Office to have them mandate that a segment of the Probate Conservator's Office be directed to work on this increasing problem. Either way, I feel this need is acute and needs rapid resolution.

If you have any questions or if I can help in this process in any way, please let me know.

Yours truly,

Ian D Barlow, MD

Ian D. Barlow, M.D.

IDB:jab

cc: Sophia Chang, M.D.
Bill Haskell

St. Mary's Hospital and Medical Center
HIV Services

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July 24, 1992

Sandra Hernandez, M.D.,
Director, AIDS Office
Mr. Reggie Williams
Ryan White/Care Planning Council
The AIDS Office, Department of Public Health
City and County of San Francisco
25 Van Ness, Suite 500
San Francisco, California 94102

Dear Gentlepersons:

It has come to my attention that there are continuing difficulties in establishing a program for probate conservatorship for persons with HIV-related dementia.

To review, it was agreed by the City and County, as an integral support factor to the CARE Unit (AIDS dementia unit, 4-South) of St. Mary's Hospital and Medical Center, that a probate conservatorship mechanism be established as soon as possible. Due to the uncertain legal climate of holding patients with HIV-related dementia against their will, we requested that the City and County give us a "Hold-Harmless" agreement. This request was submitted and denied, but firm assurances were made that the establishment of a probate conservator would be rapidly pursued. Consequently, since opening the CARE Unit in February of 1991, we have been awaiting institution of this program.

As we understand, protracted negotiations with a candidate agency to manage this program did not work. However, the need for this program is still acute. Although assets are understandably very short, we believe this program is still desperately needed. As you know, many people are referred to us who are indigent and isolated, have no support system, or are unable to make an informed consent; consequently, Durable Power of Attorney forms for Health Care and Finance are unavailable.

In conclusion, we wish to underscore the City and County's earlier commitment to help solve this legal dilemma and urge that this program be established as soon as possible.

Sincerely,

Daniel Ostrow, L.C.S.W.
Program Director

IDB:jab

cc: Kathleen Kearney, R.S.M., V.P.
Jessica A. Clarke, M.D., Ph.D.
Sophia Chang, M.D.
Joe Jung
Bill Haskell
John Dean Greene

450 Stanyan Street
San Francisco, CA 94117-1079

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Psychiatric Care an Issue in AIDS Dementia

St. Mary's employees have discovered, he says, that AIDS dementia isn't an end-stage disease like previously thought. Often, he says, it is one of the first, not last, manifestations of AIDS.

David Jonson, program director of Coming Home, a San Francisco-based nonprofit organization that manages finances for disabled adults, says AIDS dementia patients also have no hope of getting well.

"It's going to progress and they are going to wander and not know where they are," he says. "When it reaches that stage, they are going to need 24-hour care."

Virginia Palmer, a partner at Oakland's Fitzgerald, Abbott & Beardsley, compares the problems of AIDS dementia to those of Alzheimer's, which also cannot be handled under LPS conservatorships because of the restrictions on medically based conditions.

She recently represented the family of an Alzheimer's patient who was placed under a probate conservatorship because he was unable to handle his financial affairs. He will live at his own home, but be under his family's care.

"When he becomes unable to stay at home any longer, we will not have the authority to put him in a locked-care facility," says Palmer, who temporarily served as an Alameda County probate commissioner about four years ago. "I don't know if we will in this case be able to meet the requirements of an LPS conservatorship."

MAYA ALLERUZZO

DAVID JONSON: "If I was a little bit confused, I wouldn't want to wake up in a locked psychiatric ward," says the program director of Coming Home, an organization that manages finances for disabled adults.

'WOULDN'T WANT TO WAKE UP IN A LOCKED WARD'

The question is whether AIDS dementia patients can be legally forced to do what's in their best interests, even if that contravenes their will.

Jesson, of the city attorney's office, says there's reason to believe that power already exists. She points to a March 29, 1989, opinion by the AG's office which concluded that patients with Alzheimer's "and other organic brain disorders" are eligible for evaluation and treatment under §5150 of the Welfare and Institutions Code.

"For purposes of Lanterman-Petris-Short," wrote Deputy AG Clayton Roche, "the subcommittee report contains strong evidence of legislative intent that the term 'mental disorder' was intended to encompass virtually any abnormal mental condition, whether of organic, non-organic or of unknown cause."

The opinion, Jesson says, seems to give leeway "to argue that AIDS dementia — as I understand it — falls under LPS." She admits, however, that she might be wrong.

Commissioner Yaggy, cautioning that she hasn't seen the AG's opinion, notes that such opinions are of limited use. "It's a state agency saying what they think it means," she says. "But it's not a court saying, 'This is what we think it means.' "

Even if the AG's argument is valid and AIDS dementia patients can be handled under LPS conservatorships, some health care professionals contend they should be housed in a separate ward — especially since such patients have moments of complete lucidity up until they die.

"If I was a little bit confused," says Jonson, of Coming Home, "I wouldn't want to wake up in a locked psychiatric ward. And the psychotropic drugs are certainly not appropriate."

"Optimally," says Leary, of San Francisco General, "they should be in a setting where all of the patients have AIDS dementia and programs can be focused on their special needs. It's not really in their best interests to be on a ward with patients who may be very aggressive or psychotic because of other psychiatric conditions, such as manic depressiveness or schizophrenia."

Palmer, of Fitzgerald, Abbott, says conservatorship cases of all types can be among the saddest to come before a judge or commissioner.

"When I sat as a commissioner for a short period of time in '87 and '88," she says, "one of the most touching cases I had was a woman who had become so physically ill that she could not care for herself. And when I ordered a conservatorship, she burst into tears and said, 'You're telling me I'm not a human being anymore.' "

"You try to honor their independence," Palmer says, "their sense of what they want and what they can do — and try to accommodate that as much as possible."

THE RECORDER • THURSDAY, JULY 9, 1992

Parceling Out Psychiatric Care

Conservatorship laws are murky when it comes to AIDS dementia

By MIKE McKEE

When legislators revised California's mental health statutes in 1969, they had the good intention of protecting people from being committed to psychiatric institutions against their will.

But those laws are now the focus of debate about how they should apply to people with AIDS dementia, a disease that attacks the brains of its victims, leaving them confused, unable to care for themselves, and with a tendency to wander.

While no health care professional advocates going back to the days when people were locked away, some argue that the law, as written, denies AIDS dementia patients proper care.

AIDS and the Law

It all comes down to interpretations of Welfare and Institutions Code §5150.

Some health care professionals and attorneys say that because AIDS dementia is considered a medical condition, not a psychiatric one, people suffering from the illness may not be placed under conservatorships that would provide access to long-term psychiatric care.

But others argue that the law doesn't preclude a more stringent conservatorship for people suffering from medically induced dementia. This theory is bolstered by a 1989 California attorney general's office opinion about Alzheimer's disease.

Add to the conflict another argument — that it would be unconscionable to lump people with AIDS dementia in with severely disturbed, and possibly violent, psychiatric patients — and you have a confusing mess.

No resolution is in sight, which worries health care professionals.

"We're seeing more and more people who are living longer with [the human immunodeficiency virus] and AIDS, and we're seeing an increase in the number of people who are showing signs of dementia," says Daniel Ostrow, program director for HIV services at St. Mary's Hospital in San Francisco.

"We raised this question over a year ago with the Department of Public Health," he says. "And there hasn't been a resolution yet."

A DISEASE NOT ENVISIONED IN 1969

At issue are two types of conservatorships — those arising from ordinary probate proceedings and those tied to 1969's Lanterman-Petris-Short Act, which revised Welfare and Institutions Code §5150.

Only LPS conservatorships allow involuntary commitments to mental institutions. The act allows treatment to be forced only on chronic alcoholics and the "gravely disabled," which is defined as "a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter." People suffering psychological difficulties arising from medical conditions cannot, it is widely believed, be forced into LPS conservatorships.

MERYL SCHENKER

OAKLAND'S VIRGINIA PALMER: She compared AIDS dementia cases to Alzheimer's. "You try to honor their independence, their sense of what they want and what they can do — and try to accommodate that as much as possible."

"The theory of LPS law," says San Francisco Superior Court Commissioner Carol Yaggy, "is that people can be treated and get well over time," in contrast to patients with incurable conditions like AIDS and Alzheimer's.

But San Francisco Deputy City Attorney Paula Jesson says no one knows whether lawmakers meant to exclude AIDS dementia and Alzheimer's from LPS conservatorships, because the conditions had not been discovered when the. law was written.

Because of the extreme powers granted an LPS conservator, Jesson says, the law provides many legal protections.

"It requires a jury trial on the question of grave disability, the highest burden of proof — beyond a reasonable doubt — that the person is gravely disabled, a unanimous jury verdict, and automatic termination of the conservatorship every 12 months," she says.

Once appointed, though, an LPS conservator has broad authority to make decisions about a person's life, including whether he or she should be placed in a locked setting.

"The problem with AIDS dementia patients is that they have behavioral problems which require them to be in a locked setting," says Mark Leary, chief psychiatrist of the HIV-focus psychiatry ward at San Francisco General Hospital. "That is, they wander away and get themselves into dangerous situations. . . . It's a small percentage, but significant enough to matter."

"When people have behavioral problems that are treated primarily psychiatric," he continues, "it makes sense to me that they ought to be under a psychiatric conservatorship."

In San Francisco, St. Mary's, licensed as a skilled nursing facility, is the closest thing to a true LPS facility. While St. Mary's is locked, Ostrow says, there's more freedom to come and go.

Opened in 1991, St. Mary's AIDS dementia unit has cared for 70 to 75 patients, about 12 at a time, Ostrow says. Many have been discharged to their families, partners or local hospices.

Hilarie Harris, a clinical nurse specialist at St. Mary's, says the hospital's AIDS dementia unit differs from a true LPS facility in that it isn't a licensed mental-health treatment center and has no authority to hold people against their will. If someone wants to be discharged, St. Mary's generally must comply.

"The trouble with AIDS dementia," Commissioner Yaggy says, "is that they might want to stay there on Monday, but not on Tuesday."

Ostrow foresees things only getting more difficult for facilities that handle AIDS dementia.

While requests for probate conservatorship in AIDS dementia cases are few and far between right now — only about 5 percent in San Francisco — the future doesn't look good.

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HIV Health Service Planning Council
Service Area Providers

Agency/Individual: **Walden House, Inc./Jeff Presement, Ph.D.**

Service Site: **815 Buena Vista West, 890 Hayes St.,1840 Van Ness**

Target Population: **HIV/AIDS infected substance abusers as well as clients in need of social model detoxification and safe housing.**

Client Demographics: (Number Served/Percentage of Total)
*** Note: These are unduplicated clients served during year 1.**

Male **41/95%** Female **2/5%**

White **27/63%** African American **10/23%** Latino **4/9%**

Native American **0** Asian/Pacific Islander: **2/5%**

Service Description:

We are providing 30 residential substance abuse beds. Program length varies from 6 months to three years dependent upon individual clients needs. 6 of the 30 beds are for long term congregate living. In addition to substance abuse treatment, clients receive coordination of primary medical care, in-house alternative healing, nutritional counseling, mental health services if needed, individual HIV/AIDS counseling and support groups. In addition under year two CARE funding (numbers not reflected above) we also provide aftercare services to clients that complete the residential phase of treatment and have opened a twelve bed social model detoxification program and safe house. Clients detoxify with use of herbs, acupuncture, and body work by licensed practitioners. They can then choose to enter residential and or day treatment at Walden House or remain in safe housing until an appropriate placement can be found. During this time clients who usually have not received primary heath care for their HIV disease are linked with other CBO's to receive care.

Funding Sources:

Our HIV/AIDS services are funded through CARE FORMULA and CARE SUPPLEMENTAL contracts. Our agency, which provides services to over 400 clients is also funded by contracts with the San Francisco Department of Public Health Community Substance Abuse Services, as well as other State and Federal Sources.

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CARE SUPPLEMENTAL BUDGET SUMMARY
April 4, 1992 - April 3, 1992
By Fiscal Year 1992 Service Categories

Service	Amount	Percent of Total
Administration	$529,739	5.0%
Case Management	$1,189,642	11.1%
Housing	$1,983,224	18.5%
Substance Abuse Treatment	$2,328,290	21.8%
Other Primary Health Care	$1,476,687	13.8%
Primary Medical Care	$2,343,048	21.9%
Psychosocial Support	$744,134	7.0%
URS Pilot Project	$99,534	0.9%
Total, Supplemental Budget	$10,694,299	100.0%

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CARE SUPPLEMENTAL BUDGET SUMMARY
(in priority order)
April 4, 1992 - April 3, 1993
By Fiscal Year 1992 Service Categories

No.	HRSA Service Category	San Francisco Service Category	Provider	Amount
Administration				$529,739
Continuing Programs				
1.	Client Advocacy	Case Management	GCHP & FTFA	$78,375
2.	Client Advocacy	Case Management	CURAS	$104,500
3.	Primary Medical Care	Case Management	SFDPH - CPHS	$60,138
4.	Case Management	Case Management	SFDPH - CMHS	$285,236
5.	Support Services - Other	Case Management	SFDPH - AIDS Office	$261,259
6.	Case Management	Case Management	San Mateo County	$79,452
7.	Case Management	Case Management	Marin County	$135,384
8.	Housing Related Services	Substance Abuse Treatment	Walden House	$223,661
9.	Housing Related Services	Substance Abuse Treatment	Baker Places	$218,196
10.	Housing Related Services	Housing Services	Shanti Project	$167,200
11.	Direct Financial Assistance	Housing Services	Shanti Project	$224,675
12.	Day and Respite Care	Other Primary Health Care	CPMC / VNH	$78,375
13.	Home-Based Hospice Care	Other Primary Health Care	Maitri AIDS Hospice	$52,250
14.	Dental Care	Primary Medical Care	UOP, School of Dentistry	$313,500
15.	Primary Medical Care	Primary Medical Care	Community Clinic Consortium	$313,500
16.	Primary Medical Care	Primary Medical Care	San Mateo County AIDS Clinic	$226,762
17.	Primary Medical Care	Primary Medical Care	Marin County AIDS Clinic	$104,357
18.	Primary Medical Care	Primary Medical Care	SFDPH - CMHS	$156,691
19.	Primary Medical Care	Primary Medical Care	St. Mary's Hospital	$261,250
20.	Home Health Care	Other Primary Health Care	CPMC / VNH	$219,973
21.	Substance Abuse Treatment	Substance Abuse Treatment	Continuum HIV Day Services	$41,800
22.	Mental Health Therapy	Psychosocial Support	CPMC / Operation Concern	$120,175
23.	Substance Abuse Treatment	Substance Abuse Treatment	UCSF AIDS Health Project	$104,500
24.	Day and Respite Care	Other Primary Health Care	SFDPH - Laguna Honda Hospital	$53,200
25.	Housing Related Services	Housing Services	Westside Mental Health	$104,500
26.	Mental Health Therapy	Primary Medical Care	Family Service Agency	$90,915
27.	Mental Health Therapy	Primary Medical Care	UCSF AIDS Health Project	$64,790
28.	Food Bank/Delivered Meals	Other Primary Health Care	Project Open Hand	$143,458
29.	Food Bank/Delivered Meals	Other Primary Health Care	Project Open Hand	$130,625
30.	Buddy/Companion Services	Psychosocial Support	BVHP Foundation	$104,500
31.	Buddy/Companion Services	Psychosocial Support	Shanti Project	$52,250
32.	Buddy/Companion Services	Psychosocial Support	Shanti Project	$130,625
33.	Transportation	Psychosocial Support	BAHSES / BWMT / MACT	$5,225
34.	Counseling	Psychosocial Support	CPMC / Operation Concern	$104,500
35.	Counseling	Psychosocial Support	Larkin Street Youth Center	$123,404
36.	Adoption/Foster Care Assist.	Psychosocial Support	S.F. Dept. of Social Services	$103,455
ubtotal, Continuing Programs				$5,042,656

All continuing programs will have a contract perid of of July 1, 1992 through June 30, 1993.

CARE SUPPLEMENTAL BUDGET SUMMARY
(in priority order)
April 4, 1992 - April 3, 1993
By Fiscal Year 1992 Service Categories
(Continued, Page 2 of 2)

No.	HRSA Service Category	San Francisco EMA Service Category	Provider	Amount
New Programs				
37.	Case Management	Case Management	Westside Mental Health	$86,973
38.	Case Management	Case Management	SFDPH - AIDS Office	$98,325
39.	Direct Financial Assistance	Housing Services	AIDS Emergency Fund	$175,000
40.	Housing Related Services	Housing Services	Larkin Street Youth Center	$106,326
41.	Direct Financial Assistance	Housing Services	Catholic Charities	$218,015
42.	Housing Related Services	Housing Services	Baker Places	$250,000
43.	Housing Related Services	Housing Services	Black Coalition on AIDS	$237,508
44.	Housing Related Services	Housing Services	Shanti Project	$500,000
45.	Substance Abuse Treatment	Substance Abuse Treatment	[To be determined]	$260,000
46.	Substance Abuse Treatment	Substance Abuse Treatment	Women's Inst. of Mental Health	$198,688
47.	Substance Abuse Treatment	Substance Abuse Treatment	Salvation Army/Harbor Light	$120,028
48.	Substance Abuse Treatment	Substance Abuse Treatment	Walden House	$375,000
49.	Substance Abuse Treatment	Substance Abuse Treatment	Haight Ashbury Free Clinic	$75,000
50.	Substance Abuse Treatment	Substance Abuse Treatment	UCSF Subst Abuse Svcs/SFGH	$250,000
51.	Substance Abuse Treatment	Substance Abuse Treatment	Baker Places	$461,417
52.	Other Primary Health Care	Other Primary Health Care	Mission Neighborhood Health Center	$110,837
			Bayview Hunter's Point Foundation	$89,692
53.	Food Bank/Delivered Meals	Other Primary Health Care	Project Open Hand	$250,000
54.	Primary Medical Care	Other Primary Health Care	Inst. for Traditional Medicine	$108,520
55.	Primary Medical Care	Other Primary Health Care	Am. College of Traditional Med.	$173,279
56.	Primary Medical Care	Primary Medical Care	Haight Ashbury Free Med Clinic	$233,134
57.	Primary Medical Care	Primary Medical Care	Planned Parenthood/PHREDA	$148,859
58.	Primary Medical Care	Primary Medical Care	UCSF AIDS Clinic (Women's)	$92,320
59.	Primary Medical Care	Primary Medical Care	Lyon Martin Womens' Health Svcs.	$180,000
60.	Mental Health Therapy	Primary Medical Care	American Indian AIDS Institute	$25,000
61.	Mental Health Therapy	Primary Medical Care	California Pacific Medical Ctr.	$131,970
62.	Uniform Reporting System	Pilot Project	Project Open Hand	$49,536
			Walden House	$49,998
63.	Probate Conservatorship	Other Primary Health Care	Coming Home Support	$66,479
Subtotal, New Programs				$5,121,904
Total, Non-Administrative Budget				$10,164,560
Subtotal, Admininstrative Budget				$529,739
TOTAL, SUPPLEMENTAL BUDGET				$10,694,299

All programs, unless otherwise noted, will have a contract period of July 1, 1992 through June 30, 1993.

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HIV HEALTH SERVICES PLANNING COUNCIL

September 14, 1992
25 Van Ness, 3rd Floor Conference Room
4:30 - 7:30 p.m.

TENTATIVE AGENDA

I. Roll Call

II. Review of Agenda and Minutes

III. General Announcements

IV. Review of City and State Budget Cuts

V. HOPWA Update

VI. Bidding of CARE Monies
- All CARE contracts rebid?
- Monitoring Score Criteria for Rebidding
- Other Options

VII. CAEAR Lobbying Update

VIII. Public Comment

IX. Agenda Development

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415 - 554-9000
FAX 415 - 431-7547

HIV HEALTH SERVICES PLANNING COUNCIL

September 14, 1992

The Minutes of this meeting are missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

October 29, 1992

The Agenda and Minutes of this meeting are missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

November 16, 1992

The Agenda of this meeting is missing.

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11/16/92

HIV HEALTH SERVICES PLANNING COUNCIL
November 16, 1992
4:30-7:30 p.m.

Minutes

Members Present: Sandra Hernandez, Reggie Williams, Marcy Fraser, Yvone Frazier, Estela Garcia, Jaime Geaga, Les Hanson, Gerald Lenoir, Gifford Leoung, Steve Lew, Kent Macdonald, J.B. Molaghan, Bob Nelson, Elliot Ramos, Eric Rofes, Laura Thomas, Patricia Underwood, Jerry Windley, Mary Jane Wood

Members Absent: Pat Christen, Maria Church, Karen Hembry, Mike Shriver, Sylvia Villareal

Staff Present: Bill Haskell, Valerie Dorr, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Agenda and Minutes

The minutes of the October 29, 1992, meeting were approved. Motion B was clarified to read:

> For the Case Management service area, equal priority be given to clinical and brokerage case management programs.

III. General Announcements

Valerie Dorr announced that in Y02 of the CARE grant there was a line item for HRSA SDP Support. Since this was not an expense allowable by HRSA in Y03, the funds for staff support will be put into the 5% administrative piece of the awards with a new line item for the Uniform Reporting System similar to the Reimbursement Unit.

Michelle Dixon announced that a mathematical error had been made in calculating the units of service (UOS) for the Rose Resnick Center. The number of 7000 rather than 700 was erroneously used to calculate UOS. Ms. Dixon asked to Planning Council to allow the revision of UOS based on 700.

A) The following motion was passed by the Planning Council:

> To accept the AIDS Office staff recommendation to change the UOS for Rose Resnick Center.

Bill Haskell announced that Gene Copello of the San Mateo AIDS Office and Anne Eshoo a Supervisor for San Mateo County had invited the Planning Council to tour the San Mateo AIDS Program. The visit is set for December 11, 1992, between the hours of noon to 5:00. Planning Council members interested in attending may contact Jon Dean Green.

Mr. Haskell also announced that San Francisco has been invited to attend the National Association of Counties meeting to present on Title I: Lessons learned by Ryan White Planning Councils. Mike Shriver will represent San Francisco at the meeting.

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Eric Rofes announced that the opening of the Americana Suites will occur on November 30, 1992 before the Planning Council meeting and invited all members to attend.

Kent Macdonald announced that the group Housing for Indepdent People was attempting to rehabilitate the Pontiac Hotel. The Pontiac is targeted for persons with mental disabilities who are low income living in the South of Market area. The San Francisco Redevelopment Agency (SFRA) had rejected the original proposal but is now reconsidering it. Mr. Macdonald asked the Planning Council to send a letter of support to the SFRA regarding the project, as the target population would include persons with HIV. Mr. Macdonald asked the Planning Council to support the notion of housing for persons with mental disabilities who are low income living in the Sixth Street corridor.

B) The following motion was passed by the Planning Council:

To send a letter of support to the SFRA for the Pontiac Hotel Project.

V. The discussion of the San Francisco Examiner Article of 11/15/92 was postponed to a later date.

VI. Facilitated Discussion with Margo Okazawa-Rey.

Sandra Hernandez introduced Ms. Okazawa-Rey. Ms. Okazawa-Rey stated that she liked to begin discussions with the group setting ground rules. She asked what the Planning Council's expected outcomes were and then stated she would set out a question to frame the discussion.

The following ground rules were established:

- To respect individual's points of view
- To be conscious of the amount of speaking time available
- Everyone must take part in the discussion
- It is the responsibility of everyone present to speak openly to each other
- Planning Council members must remember the context in which the discussion is taking place

Ms. Okazawa-Rey stated that she had read the minutes of the October 14, 1992, meeting and that she hoped the above would make this a "safe" place for the discussion to take place in.

A question was raised concerning the appropriateness of AIDS Office staff taking part in the discussion. Members noted that an unusually large number of staff were present. Issues concerning power dynamics and "safety" for the discussion were raised. The consensus of the Planning Council was that the discussion should take place among Planning Council members only. Dr. Hernandez suggested that normal Planning Council staff remain, and that the remaining AIDS Office staff carry forward the discussion at a different time and place. Staff excepting Jimmy Loyce, Bill Haskell, Valerie Dorr and Jon Dean Green departed.

Ms. Okazawa-Rey framed the following question to base the discussion on:

What is the best way to provide quality services to Communities of Color

Ms. Okazawa-Rey asked what are the problems in providing quality services to Communities of Color?

The following points were raised:

- Who provides which services, and which services should be provided by People of Color (POC) providers
- The inability to recruit sufficient POC professional staff due to POC staff shortages
- Obstacles such as language and how illness and health are perceived in Communities of Color

Eric Rofes pointed out that question still remains of which POC? Mr. Rofes stated that People of Color can not be spoken of in a monolithic way. The clients must be consulted on what they want in terms of services and providers. Gifford Leoung stated that clients may be unsure of what they want. Planning Council members stated that POC agencies began due to the historical feeling that "mainstream" agencies were not serving POC. The Planning Council also noted that bad and/or poor service from agencies was not what was wanted.

Ms. Okazawa-Rey asked what is good service? What are the standards?

Laura Thomas asked what is "multicultural"? What does it mean? Are POC served better by a large multicultural agency or by a smaller culturally specific agency? Gerald Lenoir stated that it is not an either/or question. It is not a matter of can a multicural agency provide services, it is a matter of a community wanting and needing to provide for itself.

Marcy Fraser stated that it is incumbent upon mainstream service providers to adapt to delivering culturally sensitive services. Agencies must have POC on their boards, and staff at all levels.

Eric Rofes stated that the point of it not being an either or question is important. Mr. Rofes stated that the important point is that people with HIV disease feel comfortable in getting services whereever they are. Empowerment of POC through their own communities is important. Mr. Rofes felt multicultural agencies have their place. Bridges, real bridges, must be built between POC in multicultural agencies and POC specific agencies.

Jaime Geaga stated that agencies must have communication. The tension and competitive nature of agencies is communicated to clients and effects services. Mary Jane Wood concurred stating that clients often did not want to have one agency know they were also receiving services at another agency for fear of some sort of censure.

Sandra Hernandez stated that it is often difficult to tolerate diversity. It makes many people feel angry, fearful, tense. To have meaningful bridges and collaborations, people must come to grips with the fact that diversity itself is difficult.

Margo Okazawa-Rey asked what the Planning Council's vision of diversity is in regard to multiculturalism and cultural competency?

Estela Garcia stated that speaking of assumptions and myths is helpful. It is a myth that POC agencies are adequately funded. She also stated that questions regarding multiculturalism and ethnic specific services are dynamic. A primary question is, "How do we see our uniqueness?" How to set up a continuum of care that ranges from monolingual/monocultural to bicultural to aculturated? Ethnic specific organizations have the same responsibilities in this area as other organizations do.

Eric Rofes pointed out that many mainstream agencies do work on multiculturalism to combat inherent racism. Mr. Rofes stated that ethnic specific agencies must also work on multiculturalism. There is a culture not only of racism, but of imperialism and domination.

Sandra Hernandez stated that in discussions of multiculturalism, there must be a perception regarding backlash. People of Color are becoming the majority of both the general population and in the epidemic. Some cultures feel they have ownership of the epidemic and others feel shame.

Yvonne Frazier stated that the San Francisco Examiner article fostered a perception that there is not enough for everyone. This is a particulary ugly thing in that it leads people to think, "There isn't enough to go around and "we're" not going to share."

Bob Nelson stated there is an impression given in the San Francisco Examiner article that the Big 5 agencies are going to swallow up smaller agencies. It is a bad assumption. It ignores the current efforts towards collaboration.

The point was made that the article gave the impression that the San Francisco model is crumbling. Jaime Geaga stated that POC agencies developed to deliver services. The previous model was not perfect. The current times require leadership, not an overwhelming fear due to an environment of scarcity.

Jerry Windley stated that the article played out the ownership of HIV felt by some gay white men. Many gay white men feel the disease hit them first and hardest. HIV took and continues to take a huge toll on this community that many have spent years fighting with time, money and great efforts. It is difficult to let this go and acknowledge the changing face of the disease.

Elliot Ramos asked what is the Planning Council's plan? How will this effect how RFPs are released, and decisions regarding where funding dollars will go?

Pat Underwood stated there must be a balance between providing essential services and providing culturally specific services. What services should be provided by POC to POC balanced with what general services does everyone need.

Margo Okazawa-Rey stated the tendency is to go for solutions. Ms. Okazawa-Rey asked what the framework, the vision is on which services will be based? What is the bigger picture?

Yvonne Frazier stated that when the Planning Council began there was a great deal of work done on the mission of the Planning Council. It was something to return to when the group felt lost. Pat Underwood stated that part of the mission is a commitment to essential HIV services.

Kent Macdonald stated that the Planning Council rarely discussed planning issues. A great deal of time is spent in day-to-day tasks. Sensitivity and multiculturalism are lofty ideals and ambitions. How to implement themon a day-to-day, practical and long term basis.

Sandra Hernandez stated that empowerment has become a catch all phrase. There is a tendency to think that money equals empowerment. Dr. Hernandez feels empowerment comes from within, not through money. She acknowledged it is hard to be empowered in an environment of poverty. Discussions of empowerment and dollars should not always be associated.

Estela Garcia spoke of double standards. A gay white man from the Philadelphia Planning Council related to her how ten years ago no one believed that a gay agency could handle money or deliver services. It took years for his agency to develop fully. The man stated an agency that is two years old can not be expected to have the same organizational development as a 10-20 year old agency. Margo Okazawa-Rey stated that there must be an evaluation of expectations. Programs must be examined developmentally. Giving an agency money does not automatically cause organizational development to occur.

Members stated that the Planning Council must examine the People of Color report and review which recommendations can be implemented and how.

The consensus of the Planning Council was that the above discussion needed to be part of an ongoing dialogue. Sandra Hernandez stated that it would be retaken up at the 12/21/92 meeting. The following issues need to continue to be addressed:

- Further discussion (3 meetings)
- Further community input
- Which recommendations in the POC report to implement and how to prioritize
- Create a vision upon which services are based
- Examine recent epidemiological statistics for where the epidemic was, is, and will be
- Continue the fiscal education of the Planning Council on the current budget crises
- Examine short term and long range planning.

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